VS A15 (4) 15M 10/57

| ARYLAND STATE DEPARTMENT | OF HEALTH-BALTIMORE, 1 | 8 |
|--------------------------|------------------------|---|
|--------------------------|------------------------|---|

CERTIFICATE OF DEATH

8 (19157

| - | 9207 | CERTIFICA | IE OF DEATH | Reg. Dist | . No. |
|----|---|--|--|--|---|
| 7. | 1) PLACE OF DEATH o. COUNTY Harford | MARYLAND | 2. USUAL RESIDENCE (Where deceased a. STATE Mary land | b. COUNTY | e befare admission) |
| | b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest lawn) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (Il outside corpor | ate limits, write RURAL and gi | ve nearest tawn) |
| | d. NAME OF HOSPITAL (If not in haspital, give stree OR INSTITUTION | et address) | d. STREET ADDRESS FEDERAL HILL ROS | ad | e. IS RESIDENCE ON A FARM? YES NO |
| | 3. NAME OF First DECEASED (Type or print) GETTYLE | Middle Maryart Mary | Albers 4. DATE OF DEATH | August | Day Year |
| | female white wipo | WED DIVORCED | August 9 1886 | last birthday) Manths [| YEAR IF UNDER 24 HRS. Days Hours Min. |
| 1 | 10a. USUAL OCCUPATION (Give kind af wark done 10 during mast af warking life, even if retired) | b. KIND OF BUSINESS OR INDUST | RY 11. BIRTHPLACE (State or foreign of | iuntry) 12. CITIZ | ZEN OF WHAT COUNTRY |
| 1 | 13. FATHER'S NAME Contad Kohles | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | arbara J. Ho | ahn |
| / | (Yes no, or unknown) (If yes, give war or dates of service) | 6. SOCIAL SECURITY NO. 17. INI | eughtu - Mary | Harpey Ja | irrettsville M |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Candilians, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) | greprovascular y pertensivo Anterio | sclentic Cardisvas | ular Diceaux | yrs. |
| | PART II. OTHER SIGNIFICANT CONDITION 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | (Enter nature of injury in Part I or Part | | 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| | | le Nat while facto | CE OF INJURY (Hame, form, 20f. (City street, affice bldg., etc.) | ar town) (Co | aunty) (State) |
| | 21. I certify that I attended the decerative an 27 August 19 ACTUAL SIGNATURE Amen A Column | | nccurred at 9:30 AM, from ADDRESS (SI | | e date stated above |
| | PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, PREMOVAL (Specify) 8-4-60 | 22c. NAME OF CEMETERY OR Holy Redee | crematory 22d Locat | Maryland MON (City, town, or county) Limore. Md. | (State) |
| 1 | 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 530 | 5 Harford Rd. | 24a. REC'D BY REGIST AUG 2 | RAR 24b. REGISTRAR'S SIG | NATURE, |

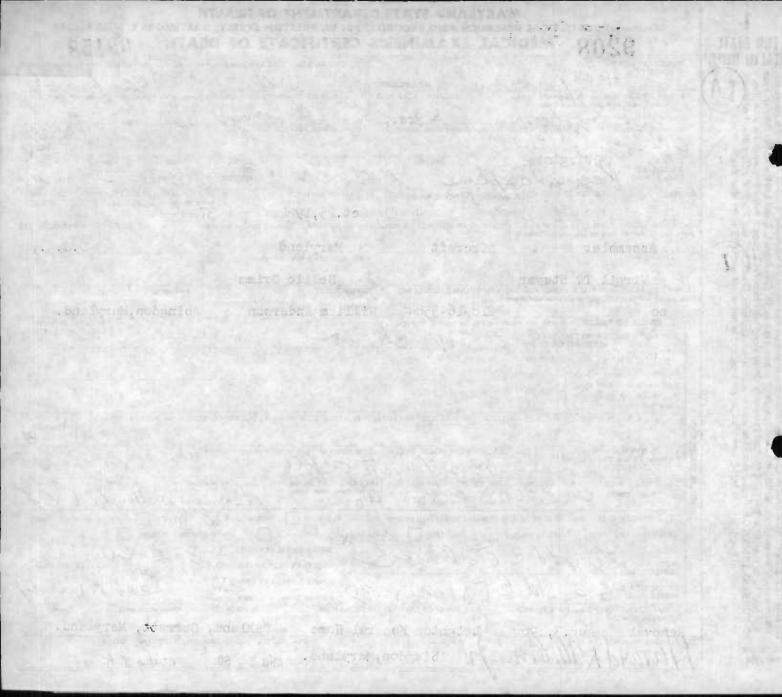
| HE OF DEATH | MARKING THE PARTY OF THE PARTY | |
|-------------------|---|---|
| | | |
| | | The second of |
| | | |
| | | |
| | | |
| | | |
| Contractor Design | | |
| | | |
| | | Land State of the |
| | | Military Health and |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

FOR STATE HEALTH DEPT TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a like is a please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Inversel director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3_Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-page/1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | |
|--|-----|-------------------|--|--|--|--|
| | | | CERTIFICATE OF DEATH (19158 | | | |
| COUNTY H | Ind | 2/ W D 1/ W W T D | USUAL RESIDENCE (Where deceased lived, if Institution: Residence before access STATE | | | |

| | | PLACE OF DEATH | 2. USUAL RESIDENCE (Whare dacaesad livad, If Institution: Re | sidence before admission) |
|----|---------------|--|--|-------------------------------|
| 1 | | e. COUNTY Harland | e. STATE b. COUNTY | had |
| 1) | | b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL end | ove naaresi town) |
| | | A burdon 4 yrs., | 1 4 fingdo | |
| 1 | | d. NAME OF HOSPITAL OK INSTITUTION (if not in hospital, give straet address) | d. STREET ADDRESS | IS RESIDENCE ON A FARM? |
| X | (| The Point was | | YES NO D |
| - | | NAME OF DEVINGEN Middle | Last 4. DATE Month | Dey Year |
| | | (Type or print) Kagmer Opephine AN | dersor DEATH Mynes | 2 19 60 |
| | 5. | SEX COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | DATE OF BIRTH 9. AGE (In years IF UNDER 1 Y lest birthday) Months D | |
| | | WIDOWED DIVORCED | Oct.25,1922 37 yrs. Months D | ays Hours Min. |
| | | . USUAL OCCUPATION (Give kind of work ne during most of working life, even if retired) | Y 11. BIRTHPLACE (State or foreign country) 12. CITIZ | EN OF WHAT COUNTRY? |
| 1 | 13 | Assembler Aircraft | Maryland 14. MOTHER'S MAIDEN NAME | U.S.A., |
| | 13. | LULIEN 2 HAME | 14. MOTHER'S MAIDEN NAME | |
| / | 15 | Virgil T. Steyer WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 1 | Nellie Grimm | |
| | | s, no, or unkown) (Ifyasgiva warordalas of servica) | | |
| | - | | illiam Anderson Abingdon, Ma | |
| | | 18. CAUSE OF DEATH [Enter only one cause per lina for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: | | ONSET AND DEATH |
| | | IMMEDIATE CAUSE (a) | | |
| | | DUE TO | | |
| | | Conditions, if any, which (b) | | |
| | | (e), stating the undarlying DUE TO | | A DESCRIPTION |
| | | cause last. (c) | | |
| | No. | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 | 19. WAS AUTOPSY PERFORMED? |
| 1 | S | | | YES NO |
| | CERTIFICATION | 206. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. | nter natura of Injury in Pert I or Pert II of Item 18.) | |
| | 7 | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, ferm, † 20f. (City or town) (Count | y) (Stete) |
| | MEDICAL | Hour SM. 8 2 16 0 While Not While Sp.m. 8 19 et work et work | one A bingdon Han | ford of |
| | | 21. I certify that I took charge of the remains described above, he | ld an Autopsy . Inspection . Inquiry . | and in my opinion |
| | | death resulted from: Natural causes . Accident . Suici | de . Homicide . Undetermined manner . | |
| | | 4 - 11 P P - Canal | CHIEF MEDICAL EXAMINER \ 8-9-6 | 0 |
| | | SIGNATURE CONTRACTOR C | M.D. ASSISTANT MEDICAL EXAMINER | DATE SIGNED |
| | | EXAMINER'S GPYALD CPIL MOS-1 | DEPUTY MEDICAL EXAMINER DEL | Air ul |
| | 22e | . SURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR REMOVAL (Specify) | Address (Streat, city, town, or county) CREMATORY 22d. LOCATION (City, town, or country) | (State) |
| 1 | | Removal Aug. 3,1960 Leighton Funer | al Home Oakland, Garrett, Ma | ryland. |
| 1 | 23 | FUNERAL DIRECTOR ADDRESS | 240. REC'D 8Y REGISTRAR 24b. REGISTRAR'S SIG | NATURE |
| 1 | 1 | Traya Michael Abingdon, M | laryland BATE AUG 5 '60 arthur & | Kraus |
| U | _ | | | |



law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH 9186 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

09159

| | 1. PLACE OF DEATH O. COUNTY HAR FORD MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY b. COUNTY b. COUNTY | | | | | |
|---|---|--|--|--|--|--|
| 3 | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) HAVRE OF GRACE 5 DAYS | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Stewarts town | | | | |
| 1 | d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION HARFORD MEmorial Hosp. | d. STREET ADDRESS on a parm? yes \(\sigma \) no \(\sigma \) | | | | |
| | 3. NAME OF DECEASED (Type or print) MAUDE MELINDA | AYRES OF DEATH August 2 1960 | | | | |
| | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH A U C 7, 1882 9. AGE (In years lift UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIE OWN HOME | MARYland U.S.A. | | | | |
| | William CARMAN | HARY CARRIE SNYDER | | | | |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 173-32-6148 m. | is Ishir mechany stewartstown Pa | | | | |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) | lenvillage Strys lenvillage Strys lenvillage Strys | | | | |
| | | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \(\subseteq \) NO | | | | |
| | | D. (Enter nature of injury in Part I ar Part II af item 1B.) | | | | |
| | | ACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) tary, street, affice bldg., etc.) | | | | |
| | 220. SIGNATURE A DO P. LOSSE AS | July 28 1960, to Cluy 2 , 1966, that (I) (we) last leath accurred at 2M, from the causes and an the date stated abave. M.D. ATTENDING MED STAFF SIGNED PHYS. 8-2-60 | | | | |
| Q | 23g. BURIAL, CREMATION, 23b. DATE THEREOF BREMOVAL (Specify) 8-4-1960 275W ARTS | TOWN STEWARTSTOWN, YORK CO, PA. | | | | |
| 5 | Zenneth Washin Stewartets | ur Pa Date AUG 5 '60 2Sb. REGISTRAR'S SIGNATURE | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN

VR A1S (4) 1SM 9/59

8

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

09160

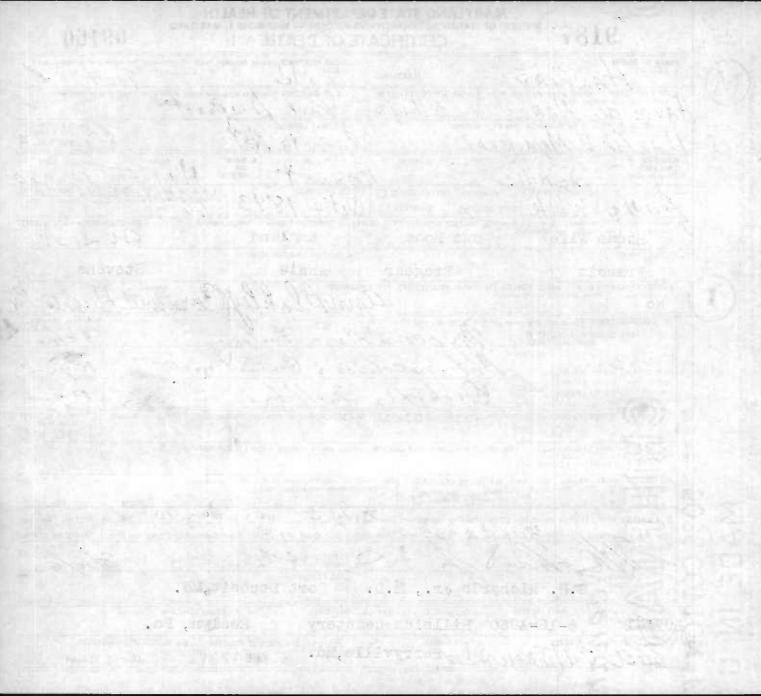
| 1 | | | 100 |
|-----|--|---|---|
| - | 1. PLACE OF DEATH a. COUNTY HAPFORD MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence o. STATE b. COUNTY | e before admission) |
| | b. CITY OR TOWN (If autside carporate limits, write RURAL and give rearest tawn) | c. CITY OR TOWN (If autside carporate limits, write RURAL and gi | ve nearest town) |
| , ' | d. NAME OF HOSPITAL (If not in hyspital, give street address) OR INSTITUTION ARE FOR L. MEMORIAL | RAPORTS APT OTX | e. IS RESIDENCE ON A FARM? YES NO P |
| | 3. NAME OF DECEASED (Type or print) Dennic Middle | Bennett 4. DATE OF DEATH August | Day Year 10 1960 |
| | -fenale White WIDOWED DIVORCED | Well + 1012 66 yrs. | Days Hours Min. |
| | during most of warking life eyen if retired) Own Home | England Qu | EN OF WHAT COUNTRY? |
| | 13. FATHER'S NAME Francis Tregear | Annie Ster | rens |
| - | | MNBlabley Cornwells | Leighto, Pa |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditions, if ony, which gave rise to immediate couse (a), stating the under-lying cause last. (b) DUE TO DUE TO (c) | Lis é tailore Losis Generaliques. Millihos | INTERVAL BETWEEN ONSET AND BEATH |
|) | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| | | D. (Enter nature of injury in Part I ar Part II af item 18.) ACE OF INJURY (Hame, form, 20f, (City ar town) (C | aunty) (State) |
| ii. | | ctary, street, affice bldg., etc.) | |
| | 21. I certify that (I) (this haspital) attended the deceased fram. saw the deceased alive on Desperation 19 60, and that deceased size of the Richards Jr., M.D. | 150 | e, that (I) (we) last date stated above. |
| | 23c. NAME OF CEMETERY O HILLSIDE CE | | (Stote) |
| | PUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS OF PETTYVII | DATE AUG 12'60 25b. REGISTRAR'S SIG | |

the attending physician and completely filled or by the funeral director. Then please remove carban popers. Pages 1 and 2 shauld be filed with e law requires that the death certificate be executed within 24 hr. hysician. may be revolued by the haspital ar attend. Thysician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached far use as the burial-transit permit. Then please remove carban popers. Pages 1 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN

VR A15 (4) 15M 9/S9

eurs ofter death. Page 4



VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 9188

| Н | 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
|----|--|--|
| | O. COUNTY HARFORD MARYLAND | O. STATE MARULAND b. COUNTY HARFORD |
| | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (A outside corporate limits, write RURAL and give nearest town) |
| | HAURE OF GRACE 48 HRS. | HAURE OF GRACE |
| 11 | d. NAME OF HOSPITAL (If not in hospital, give street oddress) , OR INSTITUTION | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| | HAKFORD MEMORIAL HOSP. | 209 J. Union AUE, YES NO |
| | 3. NAME OF First Middle | Last 4. DATE Month Day / Year |
| | Type or print) | BEST DEATH AUGUST 18 1968 |
| | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Months Days Hours Min. |
| H | PEMALE WhitE WIDOWED DIVORCED | Tet. 5, 1080 80 yrs. |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | STRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| 1 | HOUSEWIFE HOME | NEW YORK 11.S.H. |
| | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| 1 | GEORGE VAN VAIKENburg | Elia BRAGG |
| | (Yes, no, or unknown) (If yes, give war or dates of service) | FORMANT Address |
| | - NO G. | ARNOLD PAFFENBACH MAVIRE DE GRACE MD. |
| | 1B. CAUSE OF DEATH [Enter only one cause per line fow (s), (b), and (c).] | MINTERVAL BETWEEN OMSET, AND DEATH |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | MANIA (BANIAMIA) |
| | DUE TO | IN IVEN CONTRACTOR |
| | Conditions, if ony, which | 1 millionitio |
| | gove rise to immediate | C. S. Mary Ville |
| | couse (o), stoting the <u>under-</u> lying couse lost. | my H Gras Allo |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAT DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 20g. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | PERFORMED? YES NO |
| 1 | 206. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH | D. (Enter noture of injury in Port I or Port II of item 1B.) |
| | | |
| | - ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' | ACE OF INJURY (Home, form, 20f. (City or town) (County) (State) |
| | Hour o. m. P. m. 19 While Not while of work of work | |
| | 21. I certify that (I) (this haspital) attended the deceased fram | 1/-6 1960 ta X / /) 1961 that (1) (we) last |
| 9 | saw the deceased alive an 19 Aand that a | leath accurred at A. M. fram the causes and an the date stated above. |
| 1 | 22o. SIGNATURE | 22b. DATE |
| 1 | 1 / NILLOYIW | ATTENDING MED. STAFF SIGNED DIRECTOR PHYS. |
| 7 | 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
| | Trant (type) | |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O | R CREMATORY 23d_LOCATION (City, town, or county) (Stote) |
| | BURIAL AUG. 22 1960 EAST GIPEL | ENBUSHGEM NEWSSELAER CO. N.Y. |
| | 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| | A.Madisen Mitchell HAVEF DEGI | PACE NO DATE AUG 23'60 Curling & Kinus |
| | THE THE PARTY OF T | |

High to the state of the state 3 Dinax was I have also been hard AND CONTRACTOR AND AND AND ADDRESS OF THE PARTY OF THE PARTY.

9200 **CERTIFICATE OF DEATH** Reg. Dist. No 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO X Month Year Day 24 19 60 Aug. 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? Address Pylesville Md. INTERVAL BETWEEN ONSET AND DEATH I MC. 6 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO (County) (State) 24 Aug , 1960 that I last saw the deceased and that death occurred at 1212 M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 22d. LOCATION (City, town, or county) (State) Maryland 24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

| | DESCRIPTION N | | | | |
|---------------|---------------|--------------|------------------|------------|------------|
| 10 10 10 10 | | ITABO AO STA | CERTIFICA | 190 B | |
| | | | | | |
| | | | | | |
| | ULTURE THE RO | 1,300 | Peters Live | 0212000000 | |
| | | | | | |
| | | | | | |
| | HISTORY | Test by or | A PA | | |
| | | | | | |
| | | | | | |
| | | , illustra | no les en circol | | |
| | | | | | |
| | | | | | |
| | Dis organia. | G CTOL . THE | te asserbulity | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| HOLDER TO THE | | | | | Can Proper |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 9189

09163

| | _ | | |
|-----|-------------|---|---|
| M | | PLACE OF DEATH O. COUNTY HARFORD MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY |
| | ŀ | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | 4 | AURE DE LIRALE 2 days. | ZioN A7X-2 |
| 71 | 11 | d. NAME OF HOSPITAL (If not in hospital, give street oddress) | d. STREET ADDRESS IS RESIDENCE ON A FARM? |
| | A | PRIDRO MEMORIAL HOSTILAL | North East Rd. YES NO NO |
| | - (| NAME OF DECEASED (Type or print) James Thomas | PARPENTER 4. DATE OF DEATH AUGUST 4 1960 |
| | 5. 9 | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In yeors IF UNDER 1 YEAR OF UNDER 24 HRS. lost birthday) Months Days Hours Min. |
| | / | MALE White WIDOWED DIVORCED | Nov. 24, 1934 3 yrs. Months Days Hours Min. |
| | 100 | D. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDI- during most of working life, even if retired) | USTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| - | | Child. | Md. U.S. |
| | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | | Kenneth CARPENTER | Kebecca Den Jamin |
| / | 15. (Yes | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT I A Address I I I F + M |
| | | NO NONE | lenneth larPenter North Eos, " |
| | | 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), opd (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| 103 | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | (omenular Hepho. t. s 48hrs' |
| | | DUE TO | |
| | | Conditions, if ony, which) (b) | |
| | | gove rise to immediate couse (a), stating the under- | LD -0 +. (.1) |
| | 7 | lying couse lost.) (c) Kheumatic Hear | T Diseased Congestive Failure |
| | CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BL | IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? |
| | FICA | 20. ACCIDENT WAS UNDERLYING FT. 201 DESCRIPT HOW INTURY OCCURRENT | YES NO |
| | L CERTI | 206. ACCIDENT WAS UNDERLYING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ED. (Enter noture of injury in Port I or Port II of item 18.) |
| | DICA | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. F | PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) octory, street, office bldg., etc.) |
| | MEDI | p, m. 19 of work of work | |
| | | 21. I certify that (I) (this haspital) attended the deceased fram | July 15 1963, to AU94 , 1960, that (1) (we) last |
| | | | death accurred at AM, from the causes and an the date stated above. |
| | | 220. SIGNATURE | ATTENDING MED. STAFF 22b. DATE |
| | • | 1 / Kicharo / | M.D. PHYS. DIRECTOR PHYS. D |
| | | 22c. Physician's NAME (Types H. Richards Jr. | Port Deposit mb. |
| | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | OR CREMATORY 23d. LOCATION (City, town, or county) (State) |
| 0 | | BUYIAL 8-7-1960 Hopewe | 1 (em. (Near) PortDeposit md. |
| 1 | 24. | FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 10. | 1 | emans, Mc Mullen Rising SI | in Md. DATE AUG 8 '60 Cirling S. Kraus |

may be retained by the haspital ar attend. Inysician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or remayal, and in any event, within 72 haurs after death. law requires that the death certificate be executed within 24 ha TO HOSPITAL OR ATTENDING PHYSICIAN

VR A15 (4) 15M 9/59

urs after death. Page 4

carl! the transfer designation of the transfer of the edames inwars farence by the thinky Marine Commence of the Commenc very e Henneth Carpenter Horth East My the transmission of the property of the commence of the second states of Commence of the Commence of th

| | | | | Š |
|---|---|--|--|---|
| haves after death. Page 4 | The funeral director, | and 2 should be filed with | 0 | 7 |
| th certificate be executed within 24 | ding physician and campletely filler | ise remave carban papers. Pages 1 | y event, within 72 haurs after death. | |
| TO HOSPITAL OR ATTENDING PHYSICIAN To law requires that the death certificate be executed within 24 hours after death. Page 4 | may be revained by the haspital or attending hysician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled "7" by the funeral director, | page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with | the State Board of Health prior to burial, cremation, or remayal, and in any event, within 72 hours after death. | |
| TO HOSPITAL OR ATTENDING PHY | TO FUNERAL DIRECTOR: After this or | page 3 should be detached for use | the State Board of Health prior to b | |

VR A15 (4) 15M 9/59

| | 9190 | CERTIFICA | TE OF DEATH | MORE I, MARTLAI | 091 | 164 |
|-----------|---|--|---|---------------------------|--|--|
| | PLACE OF DEATH Was ford | MARYLAND | 2. USUAL RESIDENCE (WHO a. STATE | | institution: Residence before | ore admission) |
| 9 | b/CITY OR TOWN (If outside corporate limits, write RURAL and give nearest from 1980) | e c. LENGTH OF STAY IN 16 | | outside corporate limits, | write RURAL and give ne | arest town) |
| | d. NAME OF HOSPITAL (IF for in hospital give strong in National Ales | norial App. | d. STREET ADDRESS | Market & | 4. | e. IS RESIDENCE ON A FARM? YES NO |
| | NAME OF DECEASED (Type or print) First Luther | Middle | Chance | 4. DATE OF DEATH | lug 11, | 1960 |
| 5. 5 | 1 a. Hil | ARRIED NEVER MARRIED DIVORCED DIVORCED | B. DATE OF BIRTH | 1876 83 at bir | h years IF UNDER 1 YEAR Months Days | Hours Min. |
| 10a | i. USUAL OCCUPATION (Give kind of wark dane 1 during most of working life, even if retired) | Buteley | JSTRY 12. BIRTHPLACE (Stote | or fareign country) | es la 12. CITIZEN O | F WHAT COUNTRY? |
| 13. | William Ch | ance | 14. MOTHER'S MAIDEN N | VAME Office | Elips. | |
| | WAS DECEASED EVER IN U. S. ARMED FORCES? a, no. or unknown (If J. give wor or dates of service) | Underwood 17. | rs. Melvin M. | ackin- | Address & Flavre | adams I. de grave 11 |
| | 18. CAUSE OF DEATH [Enter only one couse per part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | article for (o), (b), and (c). | e compen | sation | INT | ERVAL BETWEEN SET AND DEATH 2 WEEKS |
| 3 | Canditions, if any, which (b) | 4. s. c.v | D | | | ? |
| | gove rise to immediate cause (a), stating the <u>under-lying cause last.</u> DUE TO (c) | | | | | |
| CATION | PART IN OTHER SIGNIFICANT CONDITION | ia left | lower lo | ske, | | 19. WAS AUTOPSY PERFORMED? YES NO |
| L CERTIFI | OR CONTRIBUTING MEDICAL EXAMINER) | DESCRIBE MOW INJURY/OCCUR | | | 18.) | |
| MEDICAL | Hour o.m. WI | d. INJURY OCCURRED 20e. I | LACE OF INJURY (Hame, form actory, street, office bidg., etc | n, 20f. (City or town) | (County |) (Stote) |
| | 21. I certify that (I) (this haspital) attorned to the saw the deceased alive an Arch | 11 11 | death occurred at 2 | | | hat (I) (we) l ast e stated abôve. |
| _ | 220. SIGNATURE | som D, | ATTENDING M | ED. STAFF | | 226. DATE |
| | 22c. PHYSICTAN'S NAME (Type) Edward (| 2. Loo, M. | 22d. ADDRESS | de Gr | ace, an | di |
| 230 | BURIAL CREMATION, 23b. DATE HEREOF | 23c. NAME OF CEMETERY | OR GREWATORY) | 23d. LOGATION (City | d Grace | Md. |
| 14. | FUNEBAL DIRECTOR'S SENATURE | and that | e My, DALEG | 1 0 100 | b. REGISTRAR'S SIGNATU | JRE |

. STAR SCREENINGS NOTE Street son Superior Holes Land the second of the second

VS A15 (4) 15M 10/S7

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 9210 **CERTIFICATE OF DEATH**

09165 Reg. Dist. No.

| 1. PLACE OF DEATH o. COUNTY Harford | MARYLAND | 2. USUAL RESIDENCE (Where o. STATE Maryland | deceased lived. If institution: Resider b. COUNTY | arford |
|--|--|---|--|---|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 1, Bel kir | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outsi | de corporate limits, write RURAL and | give nearest town) |
| d. NAME OF HOSPITAL (If not in hospital, give stree OR INSTITUTION | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES NO A |
| 3. NAME OF First DECEASED (Type or print) Charles | Middle | lost 4. | DATE Month OF DEATH August 28. | Doy Yeor |
| 5. SEX 6. COLOR OR RACE 7. MAI | The second secon | ODATE OF BIRTH | | 1 YEAR IF UNDER 24 HRS. Doys Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farning | KIND OF BUSINESS OR INDU | Prayso | - Cer Va | U.S.A. |
| Hazel E | oner | 14 MOTHER'S MAJOÉN NAN | willer Co | max. |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 (Yes. no. or unknown) (If yes, give wor or daries of service) | S. SOCIAL SECURITY NO. 17. | nra Char | a Rightdown | |
| 1B. CAUSE OF DEATH [Enter only one couse per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CO | line for (o), (b), and (c). | is | Bel air Ma | INTERVAL BETWEEN ONSET AND DEATH 7 days |
| Conditions, if ony, which gove rise to immediate couse (o), stoting the under- | ebral arterios | clerosis | | 3 |
| lying couse lost. (c) Dia | abetes Mellitus | | | 15 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | PERFORMED? YES NO |
| | SCRIBE HOW INJURY OCCURRE | D. (Enter noture of injury in Part | I or Port II of item 1B.) | |
| A Hour o.m. Whil | | ACE OF INJURY (Home, form, ctory, street, office bldg., etc.) | 20f. (City or town) (| County) (State) |
| 21. I certify that I ottended the deced | | | | |
| actual Villard F | Mudson | ADO | N, from the causes and an t DRESS (Street, city or town, state) | he dote stated abave DATE SIGNED |
| PHYSICIAN'S NAME (Type) | | · 100 100 100 100 100 100 100 100 100 10 | | |
| 220. BURIAL SPECIFY 226. DATE THEREOF REMOVAL (Specify) 226. DATE THEREOF | But aw | R CREMATORY 22 Memorial | d. LOCATION (City, lown, or county) | 1 Commy |
| 23. FUNERAL DIRECTOR'S SIGNATURE | Darling li | DATE DATE | Y REGISTRAR 246. REGISTRAR'S SI | GNATURE |
| | | 36 | 1 OU CIVILINA | Trans |

| | CERTIFICATE OF DEATH | artse massage |
|-------|-----------------------|-------------------|
| | | Section 1 |
| | | |
| | | |
| | #0.00 | |
| | | |
| | | |
| 4 4 9 | | |
| | | |
| | | |
| | athenural les | 611 |
| | ele reinstantante let | |
| | neftitiel as: | oleif |
| | | |
| | | |
| | | |
| | | |
| | | De South to Later |
| | | |
| | | |
| | | |

ESTON STREET, BALTIMORE 1, MARYLAND AND RECORDS. MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where dacased lived, If institution, Residence before edm/ssion) a. COUNTY Page b. COUNTY is necessary, MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) director. write RURAL and give nearest town NOW. yrs .. Creswell o d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address Boar IS RESIDENCE ON A FARM? 2 with the State R NO NAME OF Middla DATE Month Day 4. DECEASED and 3 to the OF (Typa or print) DEATH Eugene 5. SEX AGE (In years | IF UNDER 1 YEAR 6. COLOR OR BACE 8. DATE OF BIRTH IF UNDER 24 HRS 7. MARRIED NEVER MARRIED age 5 may and 2 will 72 hours a last birthday) Months WIDOWED [DIVORCED YIS. June 10a. USUAL OCCUPATION (Giva kind of work in pencil in Item 18. Give Pages 1, 2, 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Page dona during most of working life, even if ratired) U.S.A., Virginia Dairy Farm Herdsman pages form PM3. 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Laura Kirby FIB Cox John COX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 8 permit. (Yas, no, or unkown) | (Ifyasgiva warordatasofservica) Examiner's Office along with a used as a burial-transit permi Louise M. Cox artificate should be executed INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), . ONSET AND DEATH DEATH WAS CAUSED BY: pue IMMEDIATE CAUSE (a) removal, DUE TO Conditions, if any, which (b) gave rise to immadiate causa "pending" DUE TO (e), stating the undarlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 0 8 cremat NO Medical ease execute the certificate, writing the wor should 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of Injury In Part I or Part II of itam 18.) 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | Auto accident, auto-auto type DEPUTY MEDICAL EXAMINER. CAUSE OF DEATH. should be forwarded to the Chief FUNERAL DIRECTOR: Page 3 buri Month, Day, Yaar 20d. INJURY OCCURRED #20e. PLACE OF INJURY (Homa, farm,) 20c. TIME OF INJURY 20f. (City or town) (County) (Steta) factory, street, office bldg., atc.) 0 While Not While at work at work prior 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection IX. Inquiry and in my opinion Accident X death resulted from: Natural causes Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL DATE SIGNED SIGNATUE DEPUTY MEDICAL EXAMINER NAME (Typa) Addrass (Streat, city, town, or county) 22a, BURIAL, CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Spacify) 0 940 Removal Vaughan-Guynn Galax, Grayson Co., Virginia. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VS. A15ME Abingdon, Md., 5M 7/59 DATE .ED

9-MARYLAND STATE DEPARTMENT OF HEALTH

Item 20b Film 271

THE PARTY OF THE P Jane 1, 21, 21, 21, 21 1.5. V. Seg 14 September 1 Boulse, M. Done by C. Bell oil on M. Done The state of the s

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9185 CERTIFICATE OF DEATH

Reg. Dist. No.

| 1. PLACE OF DEATH o. COUNTY | HARFORD | MARYLAND | 2. USUAL RESIDENCE o. STATE | RYLAND b. | | e before admission) RFORD |
|--|--|----------------------------------|---|--|--------------------------------|---|
| RURAL and give n | EL AIR | c. LENGTH OF STAY IN 16 4 YRS | c. CITY OR TOWN | I (If outside corporate limit BEL AIR | s, write RURAL and gi | ve nearest fown) |
| d. NAME OF HOSPI OR INSTITUTION CORNER | TAL (If not in hospital, give street HOME OF TO | HN STS, | d. STREET ADDRE | ss corner E + John a | Sts. | e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) | First | HARINE S. | DAIGER | 4. DATE OF DEATH | AUGUST | 18 1960 |
| 5. SEX | 6. COLOR OR RACE 7-MAI | NEVER MARNED DIVORCED | April 22,1 | 892 898 68 | 1 45 2 3 | Pays Hours Min. |
| during most of wor | ON (Give kind of work done 10b king life, even if retired) A, Boblitz | harity Funds | | E, Maryland | 12. CITIL | ZEN OF WHAT COUNTRY? |
| 15. WAS DECEASED EV (Yes. no. or unknown) | R IN U. S. ARMED FORCES? [If yes, give wor or dates of service] | | INFORMANT (SOU) | | Address HACE STREET, MAYYAW | |
| Conditions, if a gove rise to couse (o), stoling lying couse lost. | mmediate the under DUE TO (c) HER SIGNIFICANT CONDITIONS | APOPLEX DIABETES | T NOT RELAJED TO THE | | TION GIVEN IN PART | INTERVAL BETWEEN ONSET AND DEATH LFSS THAN HA 3 YR S |
| 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY | MEDICAL EXAMINER) | SCRIBE HOW INJURY OCCURR | ED. (Enter nature of injur | | | YES NO |
| 20c. TIME OF INJUI Hour o. m. p. m. | While | | LACE OF INJURY (Home, octory, street, office bldg | , farm, 20f. (City or town) |) (C | ounty) (State) |
| , , | THE SIDE | 60 and that deal | 1956 to h accurred a 10 11 11 11 11 11 11 11 11 11 11 11 11 | | auses and an th | ast saw the deceased e date stated abave. DATE SIGNED 18 AUGIE MAD |
| | ON, 226. DATE THEREOF August 20,1960 | 22c. NAME OF CEMETERY | | 22d. LOCATION (Cit | | (Stote) Maryland |
| 23. FUNERAL DIRECTOR | | rdusty towilling | ns St. 24a. | REC'D BY REGISTRAR | Ab. REGISTRAR'S SIG | NATURE |

| The Cartain part | | CERTIFICAT | | | |
|--|--------------------|------------------|---------|----------|-----------|
| | | | Q.Prt | Van S | |
| | | | | | |
| | AND THE PARTY | | | MALE A | 3000 |
| | CA TO STATE OF | 2 344 | METALE | | |
| | 15 E 160 I S 17 I | X | | VET ! | |
| | Parkett, Mandale | | | BOTAL I | 1000 |
| | Land Williams | | 147.4 | 1 to 100 | 1000 |
| | | i din joyen sir. | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Company of the Compan | | | | | te by |
| 10 To | | | | | |
| 100 | the Section of the | | | | |
| | | | | | |
| ELAÇAR. | 1 house to a take | | Day St. | | ALL MESON |

VR A1S (4) 1SM 9/59

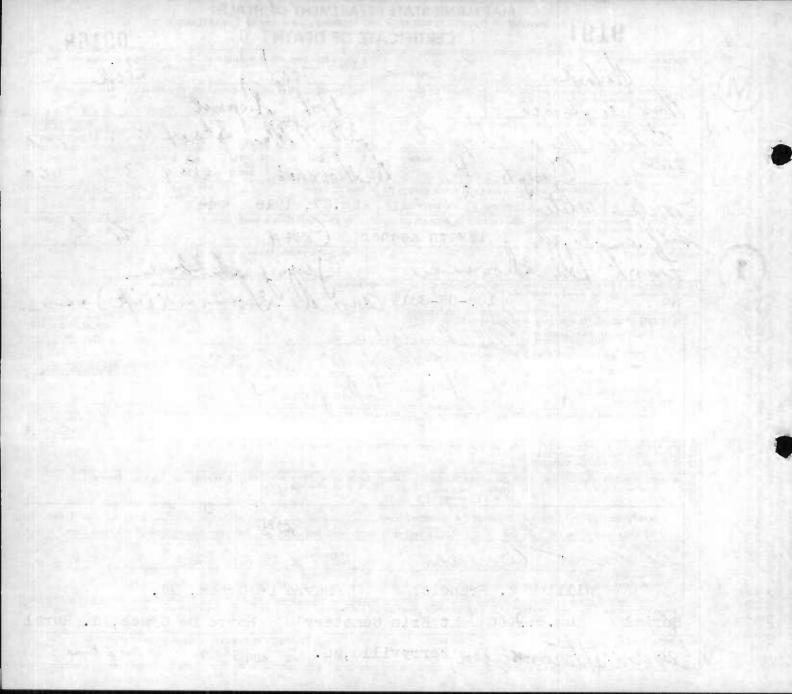
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9191

| - | 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
|---|--|--|
| | o. COUNTY Maryland MARYLAND | a. STATE Md. b. COUNTY Cecil |
| | b. CITY OR TOWN (If fourside corporate limits, write PSTAL and give newest town) Take | c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) |
| / | d. NAME OF HOSPITAL (If not in hospital, give street address). OR INSTITUTION Wesneral Associate | d. STREET ADDRESS ON A FARM? YES \(\) NO \(\) |
| | 3. NAME OF DECEASED (Type or print) Signature of the print of the pri | i Lovanne DEATH aug. 3 1960 |
| | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH Aug. 27, 1916 9. AGE (In years left under 1 YEAR IF UNDER 24 HRS. Months Days Haurs Min. |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Keepe | |
| | Frank Di Govenni | 14. MOTHER'S MAIDEN NAME |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. pg. or unknown) (If yes, give wor or dales of service) 128-05-8319 | Enn di Giovanni (wife) same |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | INTERVAL BETWEEN ONSET AND DEATH |
| | Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. | ge Jawel & R gro. Freger plvis |
| | | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? YES NO |
| | | D. (Enter nature of injury in Part I or Port II of item 18.) |
| | | ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.) (City or town) (Caunty) (State) |
| | 21. I certify that (I) (this hospital) attended the deceased fram. sow the deceased alive on 500 and that a | death occurred of the form the causes ond on the dote stated obove. |
| | 220. SIGNATURE M. L. Prender | M.D. PHYS. MED. STAFF PHYS. 22b. DATE SIGNED 8-4-816NED |
| | 22c. PHYSICIAN'S NAME (Type) William K. Brendle | Havre De Grace, Md. |
| | 230. BURYAL CREMATION. 23b. DATE THEREOF Aug. 6,1960 Mt Erin | emetery Havre De Grace, Md. Rural |
| E | 24 UNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS PERTYVII | 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE DATE AUG 5 '60 Chilms S. Krous |



| | | | 921 | 2 | CERTIF | ICATE O | F DEATH | 1 | | Reg. Dist. f | 9169 No. | |
|-----|-----------------|--|---|--|--|---|---|--|--|---|---|-----------------------|
| M | 1. P | . COUNTY | Hafford | | MARYLA | TATE OF STAT | RESIDENCE (Wh | | ved. If institutio b. COUNTY | n: Residence b | | on) |
| | b | CITY OR TOWN | (If outside corporate limi | its, write c. LEI | NGTH OF STAY IN | 1 1b c. CITY | OR TOWN (If o | | e limits, write RL | | | |
| | | RURAL ond give r | 1 | ural) | | X | Perry | man. | (Rural |) | | |
| - X | d | OR INSTITUTION | TAL (If not in hospital, g | give street address | s) | d. STRE | ET ADDRESS | | | | e. IS RESID | DENCE |
| 1 | | Box 1 | 33 | | | | Box 1 | 33 | | | YES 🗌 | |
| | D | IAME OF PECEASED Type or print) | Fir AL | LEN | ARLIN | GTON D | ORSEY | 4. DATE OF DEATH | Augus | | | ear 9 6 |
| | 5. SI | EX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | B. DATE OF | BIRTH | 9. | 1054 | IF UNDER 1 YE | - | |
| | | Male | Colored | | DIVORCED | 1 25 00 12 00 | | 1879 | lost birthday) | Months Day | rs Hours | Min. |
| 1 | 10a. | USUAL OCCUPATI | ON (Give kind of work rking life, even if retired | done 10b. KIND (| OF BUSINESS OR | INDUSTRY 11. BIR | THPLACE (Stole | or foreign coun | try) | 12. CITIZEN | OF WHAT | COUN |
| | R | ailroad | 400 | | Railroa | d | Mary! | land | | U. | S.A. | |
| | 13. F | ATHER'S NAME | | | | 14. MOTH | IER'S MAIDEN N | AME | | | | |
| 3 | | | Allen R. | Dorsey | | | Fann | ie Wil | son | | | |
| 1 | 15. V (Yes. | NAS DECEASED EV | ER IN U. S. ARMED FOR | Anniant | | | | | Addre | | | |
| | | _No | | 171. | -07-54.1 | 3 Lilli | e R. De | orsey, | Box 1 | .33, P | e e ryma | an, |
| 7/ | | | ATH [Enter only one co | | (a), (b), and (c).] | | | | | li c | NTERVAL BETY | WEEN |
| | | # PART I. DE | | | | | | | | | | |
| | | 4 | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o | 1 Car | - diac Fa | lyre | | | | | | - |
| | | 420 | IMMEDIATE CAUSE (o | | -diac Fa | lyre | | | | | | |
| | | Conditions, if | DUE TO | DI | | mphyse | ma | | | | | |
| | | Conditions, if a gove rise to a couse (o), sloting | DUE TO | Pulm | onary E | , , | 4 | | | | | |
| | z | Conditions, if a gove rise to couse (o), sloting lying couse lost. | DUE TO DOINY, which immediate the under- | , Pulm Arter | onary E | otic He | art dis | sease | | | | |
| 4 | VIION | Conditions, if a gove rise to couse (o), sloting lying couse lost. | DUE TO Dry, which (bin mediate the under- | , Pulm Arter | onary E | otic He | art dis | | ONDITION GIVE | |) 19. WAS AU PERFOR! | UTOPS MED? |
| | FICATION | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT | DUE TO DUE TO DUE TO The under- HER SIGNIFICANT CON | Pulm Arter Ditions CONTRI | onary E | H BUT NOT RELATE | art dis | NAL DISEASE C | | | 1 19 WAS AL | UTOPS MED? |
| | | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT | DUE TO DUE TO DUE TO The under- HER SIGNIFICANT CON | Pulm Arter Ditions CONTRI | onary E | otic He | art dis | NAL DISEASE C | | |) 19. WAS AU PERFOR! | UTOPS MED? |
| | CERTIFI | Conditions, if a gove rise to couse (o), sloting lying couse lost. PART II. OT 200. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY | DUE TO Ony, which of the under. DUE TO HER SIGNIFICANT CON AS UNDERLYING OF DEATH MEDICAL EXAMINER) | Pulm Arter DITIONS CONTRI | onary E | OTIC HE BUT NOT RELATE CURRED. (Enter note | D TO THE TERMIN | ORL DISEASE CO | of item 18.) | EN IN PART 1(o |) 19. WAS AL PERFORI YES | UTOPS MED? NO |
| | CERTIFI | Conditions, if a gove rise to couse (a), stoling lying couse lost. PART II. OT 200. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY HOUR OF INJUL Hour o. m. | DUE TO DUE TO DUE TO The under- HER SIGNIFICANT CON | DITIONS CONTRI 20b. DESCRIBE H ar 20d. INJURY While | ONGRY E | H BUT NOT RELATE CURRED. (Enter note) De. PLACE OF INJU | D TO THE TERMIN | ort I or Port II | of item 18.) | |) 19. WAS AL PERFORI YES | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY COLOR TO ME OF INJUIN Hour o.m. p. m. | DUE TO ONLY, which immediate the under- HER SIGNIFICANT CON AS UNDERLYING CON | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work 0 | ONGRY E | CURRED. (Enter note foctory, street, o | D TO THE TERMIN ure of injury in P DRY (Home, form, office bldg., etc.) | ort I or Port II | of item 18.) town) | EN IN PART 1(o |) 19. WAS AL PERFORI | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUI Hour o. m., p. m. | DUE TO Ony, which of the under. DUE TO HER SIGNIFICANT CON AS UNDERLYING OF DEATH MEDICAL EXAMINER) | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work 0 o | ONGRY E POOS CLESS BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED OWN INJURY OCCURRED O | De. PLACE OF INJURACELY, street, G. 3 19.0 | D TO THE TERMIN ure of injury in P DRY (Home, form, office bldg., etc. | ort I or Port II 204. (City or | of item 18.) town) | EN IN PART 1(o (Coun | 19. WAS AL PERFORI YES 19 | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY COLOR TO ME OF INJUIN Hour o.m. p. m. | DUE TO ONLY, which immediate the under- HER SIGNIFICANT CON AS UNDERLYING CON | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work 0 o | ONGRY E POOS CLESS BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED OWN INJURY OCCURRED O | CURRED. (Enter note foctory, street, o | D TO THE TERMIN ure of injury in P DIRY (Home, form, office bldg., etc.) 60, to at 3:30 | ort I or Port II 204. (City or 8/30. PM, fram 1 | of item 18.) town) 19.60 he causes an | (Coun |) 19. WAS AL PERFORI YES | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY Hour o.m., p. m. 21. I certify !! | DUE TO ONLY, which immediate the under- HER SIGNIFICANT CON AS UNDERLYING CON | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work 0 o | ONGRY E POOS CLESS BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED OWN INJURY OCCURRED O | De. PLACE OF INJURACELY, street, G. 3 19.0 | D TO THE TERMIN ure of injury in P DRY (Home, form, office bldg., etc.) 60, to | ort I or Port II 201. (City or 8/30 PM, from 1 | of item 18.) town) 19.60 he Causes at | (Coun | 19. WAS AL PERFORI YES iy) saw the date stated | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY CO. TIME OF INJUIN Hour o.m. p. m. 21. I certify !! | DUE TO ONLY, which immediate the under- HER SIGNIFICANT CON AS UNDERLYING CON | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work 0 o | ONGRY E POOS CLESS BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED OWN INJURY OCCURRED O | De. PLACE OF INJURACELY, street, G. 3 19.0 | D TO THE TERMIN ure of injury in P DRY (Home, form, office bldg., etc.) 60, to | ort I or Port II 201. (City or 8/30 PM, from 1 | of item 18.) town) 19.60 he causes an | (Coun |) 19. WAS AL PERFORI YES | UTOPS MED? NO [|
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), sloting lying couse lost. PART II. OT 200. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY Hour o.m., p. m. 21. I certify !! | DUE TO ONLY, which immediate the under- HER SIGNIFICANT CON AS UNDERLYING CON | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While Not work of the control deceased from 1960 | ONGRY E POOS CLESS BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED OWN INJURY OCCURRED O | De. PLACE OF INJURACELY, street, G. 3 19.0 | D TO THE TERMIN ure of injury in P DRY (Home, form, office bldg., etc.) 60, to at 3:30 | ort I or Port II 201. (City or 8/30 PM, from 1 ADDRESS (Stree | of item 18.) town) 19.60 he Causes at | (Coun.,that ! last and an the cotole) | 19. WAS AL PERFORI YES iy) saw the date stated | UTOPS MED? NO [|
| 1 | MEDICAL CERTIFI | Conditions, if of gove rise to couse (a), stoting lying couse lost. PART II. OT 20a. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUITHOUT o.m., p.m. 21. I certify the contribution of the | DUE TO Ony, which immediate the under- the under- HER SIGNIFICANT CON AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) RY Month, Doy, Yea 19 That I attended the B 30 Ge Or ge T DN, 22b, DATE THEREO | Pulm Arter DITIONS CONTRI 20b. DESCRIBE H or 20d. INJURY While of work 0 deceased fro 1960 Stan: | enary E CIOSCI Ere BUTING TO DEATH HOW INJURY OCC OCCURRED OCCURRED To work To work To mand that description Shury | De. PLACE OF INJU factory, street, of leath accurred | D TO THE TERMIN DIRY (Home, form, office bldg., etc.) 60, to at 3:30 Hav re | ort I or Port II 201. (City or 8/30 PM, from to ADDRESS (Street evolut de Gr | of item 18.) town) 19.60 he causes and city or town, stign St | (Coun.,that I last and an the cototo); SO | 19. WAS AL PERFORI YES 1y) saw the didate stated DAT pt. 2, | UTOPS MED? (Sto |
| | MEDICAL CERTIFI | Conditions, if a gove rise to couse (a), stoling lying couse lost. PART II. OT 200. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIFY 100 m. m. p. m. 21. I certify the condition of the country of the co | DUE TO Ony, which immediate the under- the under- HER SIGNIFICANT CON AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) RY Month, Doy, Yea 19 That I attended the B 30 Ge Or ge T DN, 22b, DATE THEREO | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While of work 0 deceased fro 1960 Stan: | OCCURRED OCCURRED on 6 1. and that desputy sbury NAME OF CEMETE | De. PLACE OF INJURACED, street, of the accurred M.D. M.D. M.D. | D TO THE TERMIN Ure of injury in P ORY (Home, form, office bldg., etc.) OO to at 3:30 Hav re | 201. (City or Port II 201. (City or Port II 204. (City or Port II 205. (City or Port II 206. (City or II 206 | of item 18.) town) 1960 he causes and city or town, so ion St | (Coun.,that I last and an the cototo) | 19. WAS ALL PERFORM PERFORM YES 1y) saw the did date stated DAT pt. 2, | (Stol) |
| | MEDICAL CERTIFI | Conditions, if of gove rise to couse (a), stoting lying couse lost. PART II. OT 20a. ACCIDENT WOR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUITHOUT o.m., p.m. 21. I certify the contribution of the | DUE TO DOINY, which immediate the under- the under- HER SIGNIFICANT CON AS UNDERLYING [] G [] | Pulm Arter DITIONS CONTRI 20b. DESCRIBE F Or 20d. INJURY While of work of the control of the | ONGRY E CIOSCI Ere BUTING TO DEATH HOW INJURY OCC OCCURRED To work To | De. PLACE OF INJURIENT STREET, (Enter note foctory, street, of the death accurred M.D. M.D. ERY OR CREMATOR | D TO THE TERMIN Ure of injury in P ORY (Home, form, office bldg., etc.) 60, to at 3:30 Have re | 201. (City or Port II 201. (City or Port II 204. (City or Port II 205. (City or Port II 206. (City or II 206 | of item 18.) town) 19.60 he causes and city or town, so city or town, so cause, No City, town, on Aberde R 24b, REGIS | (Coun.,that I last and an the cototo) | 19. WAS ALL PERFORM PERFORM YES 1y) saw the destated DAT pt. 2, (Store) arylan Ture | UTOPS MED? NO [|

| PRIDE BY ARCHITAGE BY | | | \$ /*/ A | |
|-----------------------|---------|----------------------|------------------|-----|
| | | | t f | ar, |
| | | | | H |
| | | | | 1 |
| | | | | |
| | | | | |
| | | The part of the last | | |
| | | | | |
| | F 11177 | | | |
| | | | | |
| | | Ž. | | |
| | | | | |
| | | | (4/15) (4/16) | |

mas fraker m. M.D. 22c. PHYSICIAN'S

THOMAS J FRAHER, MD. FMO

Ground. Maryland

MED. DIRECTOR STAFF PHYS.

22d. ADDRESS US Army Hospital. Aberdeen Proving

(State)

23b. DATE THEREOF 23a. BURIAL, CREMATION REMOVAL (Specify)

001149

23c. NAME OF CEMETERY OR CREMATORY

ADDRESS

23d. LQCATION (City, tawns ar county) 2So. REC'D BY REGISTRAR

256. REGISTRAR'S SIGNATURE DATE AUG 1 6 '60

24. FUNERAL DIRECTOR'S SIGNATURE

VR A15 (4) 15M 9/S9

3 should

page 3 sh the State E

| | to tradi | | (mo) | |
|--|---------------------------------------|--------------|------------------------------|-------------|
| | modraeda | principal of | ttor-y | |
| 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 | oliviatel G-195 | pro 3 | alverl proba | Noupli al A |
| Che tangas in | 7017 | | Jan Tal | |
| of all all and all all all all all all all all all al | America II, 1250 | I - | h ografe i | and and |
| | halfetell | LANE LANE | | |
| | a, is outlineaded. | | skaliged file | |
| Street in - 1 | Zudius | emell | | |
| | productions of the state of | | | |
| | | | | |
| August 5, 160 at | Maist drawn. | | dengales | |
| All 12 wild All 12 wilder 12 wilder 12 wilder 1 word | ail to Craft books | 4 4 | Sealey W.S. Mira & Shanes | |
| | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | |

VR A15 (4) 15M 9/59

John G.

Tarring

0 0

HOSPITAL OR ATTENDING PHYSICIAN

filled

campletely

and

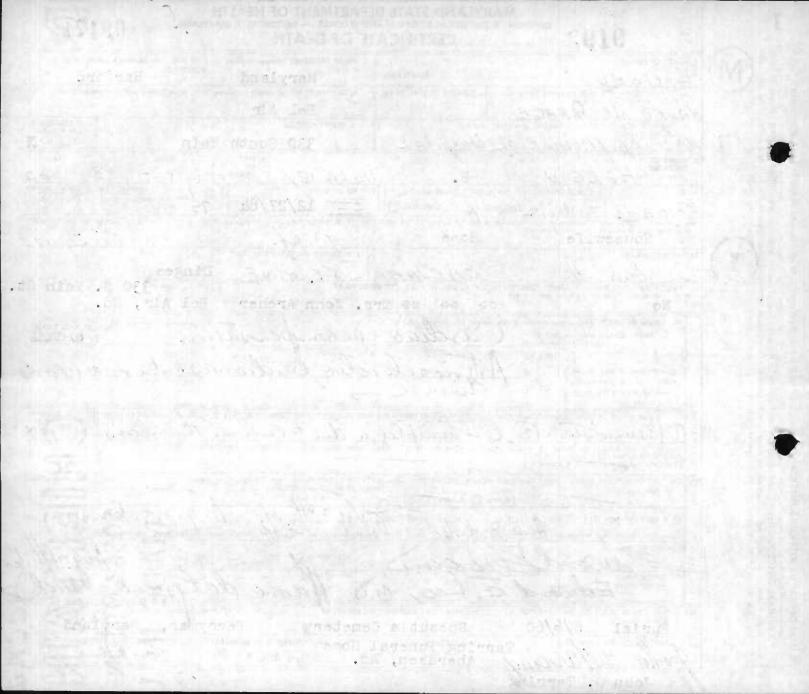
physician

attending

by

been

cate



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0109

09172

| | ar, | ith | | |
|--|--|---|--|---|
| | rect | 3 | | - |
| | P | File | N | 1 |
| | nerd | 200 | IV | |
| | In ful | pluc | - | |
| | the | s shi | | |
| ١ | Q. | pu | 1 | |
| | Pe | 10 | | |
| | Ę | ges | eath | |
| | tely | Pa | p Ja | |
| | ple | ers. | afte | |
| | COT | dod | SULS | |
| | pus | an | 2 hc | |
| | an c | carb | in | |
| | /sici | 1ve | wit' | - |
| | phy | emo | ent, | |
| | ding | Ise r | y ev | |
| | tend | pled | On | |
| | e o | en | u.p | |
| | y th | Ė | an o | |
| | q p | mit. | aval | |
| | igne | per | rem | |
| 5 | en s | insit | o | |
| 173 | pe : | I-tro | ian, | |
| 1 | has | uria | mat | |
| 100 | ate | e b | Cre | |
| 9 | rtific | as th | riol, | |
| 5 | s ce | se c | pon c | |
| 5 | · thi | ar u | or to | |
| 200 | After | ed f | Pri | |
| 2 | R: | ach | alth | |
| 2 | CTO | del | F He | |
| 200 | IRE | page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filled with | the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death. | |
| 2 | 10 | aula | Воаг | |
| 20 | ERA | 3 sh | ate | |
| מאר | SCN | age. | e St | |
| may be recomed by the maybrid of different | TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled 17-5y the funeral director, | bo | th | |
| | - | | | |

law requires that the death certificate be executed within 24 hours after death. Page

TO HOSPITAL OR ATTENDING PHYSICIAN

VR A15 (4) 15M 9/59

| | JIJ1) CERTIFICA | IL OI DEAIII |
|---|--|---|
| | 1. PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
| | o. COUNTY HAR TOR OF MARYLAND | o. STATE Maryland b. COUNTY Harford |
| | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b RURAL and give nearest town) | c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) |
| 1 | HONRE-de-GROCE 2 dous. | Manager To Bel Air |
| | d. NAME OF HOSPITAL (If not in hospital, give street oddress) | d. STREET ADDRESS e. IS RESIDENCE |
| | HORFORd Memorial Hospital | 9+9+2 Part 1204 del + 8 ON A FARM? |
| | 3. NAME OF DECEASED First Middle | Last 4. DATE Month Day Year |
| | (Type or print) LMEAL MIKE C | Taller DEATH 8 18 1960 |
| 1 | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| 1 | Male WIDOWED DIVORCED | Sept. 22.1895 lost birthday Months Days Hours Min. |
| | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS' during most of working life, everylif retired) | STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | Garage | n.J. 4,5.0 |
| 1 | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| 1 | John GaLLER | Tenknown |
| 1 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 JNI [Yes, no, or unknown] (If yes, give wor or dates of service) | FORMANT / M Address |
| | no 227-16-3560 ///a | ARIE Relly 214). MOIN TOPLUIR SAK |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (o) (b) ond (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | |
| 1 | DUE TO OTT | 0. 7. (0/2/) |
| 1 | Conditions, if ony, which) (b) Culling | deroll (Viscon 6 95 |
| | gove rise to immediate couse (a), stating the under- | Ma 00 () |
| 1 | lying cause lost. | metaras 20 grs |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I | Morely YES NO [|
| | 206. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH 10 | D. (Enter noture of injury in Port I or Port II of item 18.) |
| | | |
| | - L | ACE OF INJURY (Home, form, 20f. (City or town) (County) (State) tory, street, office bldg., etc.) |
| | Hour o.m. While Not while foot p.m. 19 of work of wark | ior, meer, once diag., etc.) |
| | 21. I certify that (I) (this hospital) attended the deceased from | Aug. 16, 1960, to Aug. 18, 1960, that (I) (we) lost |
| | | eoth occurred of P.M., from the causes and on the date stated above. |
| | 220. SIGNATURE 13 1/1 | 22b, DATE |
| | 1 Kalin Horry " | ATTENDING DIRECTOR STAFF Aug.19. 1960 SIGNED |
| 1 | 222 PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
| | J. Ralph Horky | Churchville Maryland |
| 1 | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | |
| | REMOVAL (Specify) Burial Aug. 20.1960 Western | Baltimore Maryland |
| | 24 FUNERAL DIRECTOR'S ANGUARDED ADDRESS | 250. REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE |
| 1 | Abingdo | on, Ma., Alla 22'60 34 84 |

| | | | 1010 | |
|-------------------------|-------------|-------------|------|---|
| permits have salested | | | | |
| | | and the | | |
| | | | | |
| | | | | |
| | , | | | 1 |
| | right Th | M (ME 84.7) | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| , | | | | |
| Little of the little of | | | | |
| | | | | |
| | and we have | | | |

1. PLACE OF DEA o. COUNTY

After this certificate as the

use

detached far

0

Health

burial-transit

20

cremation,

| O 1 () DIVISION OF STATISTICAL RESEARCH A | EPARTMENT OF HEALTH ND RECORDS — BALTIMORE 1, MARYLAND TE OF DEATH (19173) |
|--|--|
| PLACE OF DEATH HAR FOR L. MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY ARTORA. |
| b. CITY OR TOWN (If outside corporale limits, write c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| RURAL and give nearest town Drace & days. | 24 GAIRE- de-GRACE |
| d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION - AR 1-0 RA MEMORIAL HOSPITAL | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO |
| NAME OF DECEASED (Type or print) TO hy First Philade (Type or prin | Hines 4. DATE Month Day Year 25 1960 |
| SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Doys Hours Min. |
| 2. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS | STRY 1 ORTHPIACE (Stote or fareign country) 12. CITIZEN OF WHAT COUNTRY |

NAME OF DECEASED (Type or print) S. SEX 10a. USUAL OCC -during most 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which (b) gove rise to immediate DUE TO couse (o), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING
CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I ar Port II of item 18.) MEDICAL 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Haur a. m. While Not while of work at work p. m. 60 that (1) (we) last 21. 1 certify that (1) (this haspital) attended the deceased fram. and that death accurred at 3.45 M. from the causes and an the date stated above. saw the deceased alive an 22o: SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M.D. 22c. PHYSICIAN'S 22d, ADDRESS NAME (Type) 230 BURIAL CREMATION, 23b. DATE THEREOF MION (City, town, or REMOVAL (Specify)

250. REC'D 8Y REGISTRAR

25b. REGISTRAR'S SIGNATURE Circher S. Frank

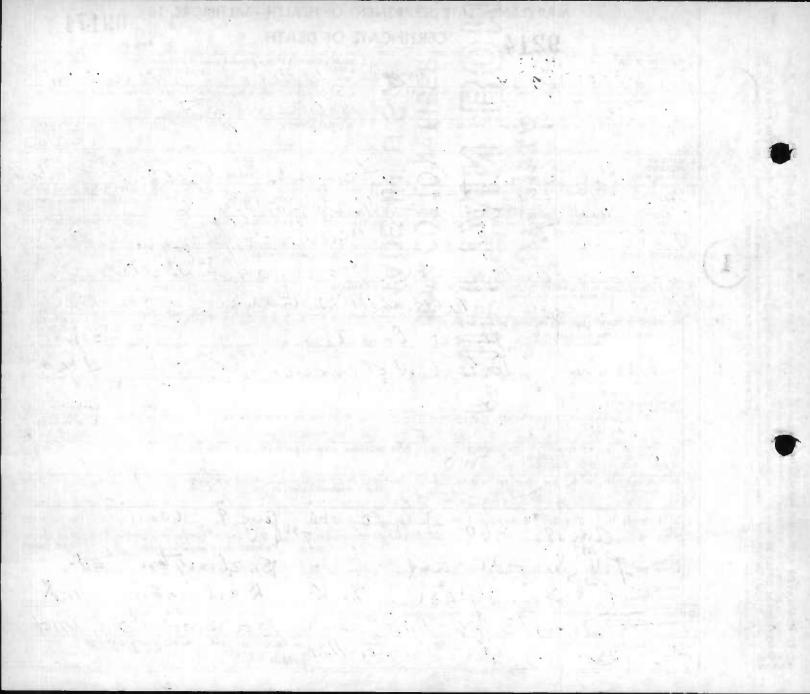
VR A1S (4) 1SM 9/59

TOTAL STREET, STREET,

VS A15 (4) 15M 9/5B

CERTIFICATE OF DEATH

| | 9214 CERTIFICA | TE OF DEATH | Reg. Dist. No. |
|-----------------|--|--|--|
| 1 | PLACE OF DEATH g. COUNTY MARYLAND MARYLAND | 2. USUAL RESIDENCE (Where deceased lived o. STATE | . If institution: Residence before admission) |
| | b. CITY OR TOWN (If outside conforted limits, write RURAL and give nearest lown) | c. CITY OR TOWN (If outside corporate lin | ton |
| | d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES NO |
| 3 | NAME OF DECEASED (Type or print) Belevier Hiddle | Loss 4. DATE OF DEATH | Rugust 9 196 |
| 5 | SEX DALL BOOKOR OR RACE 7. MARRIED NEVER-MARRIED = B | March 8, 187 | E (In years 1F UNDER 1 YEAR IF UNDER 24 HRS birthdoff Months Doys Hours Min. |
| 10 | la. USUAL OCCUPATION (Give kind of work done of the latter | TRY 11 1 BIRTHPLACE (Store or foreign country) | enna 2. SI A |
|) 1 | L'EATHERS NAME | 14. MOTHER'S MAIDEN NAME | barner |
| | is. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. IN (18. no. or unknown) (18 yes, give well-on-dotes of service) | Miss Bessie | Address |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | Lion | INTERVAL BETWEEN ONSET AND DEATH |
| | | leraous / | 441 |
| | gove rise to immediate couse (a), stating the under-lying couse lost. | N. A. L. | |
| MOITADIBITATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I | NOT RELATED TO THE TERMINAL DISEASE CON | DITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO PROPERTY NO PROPER |
| | |). (Enter nature of injury in Part I or Part II of | item 18.) |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Year Hour a. m. P. m. 19 20d. INJURY OCCURRED While Not while of work at work 20d. INJURY OCCURRED work 20d. INJURY OCCURRED foot | CE OF INJURY (Home, farm, 20f. (City or town fory, street, office bldg., etc.) | (County) (State |
| | 21. I certify that I attended the deceased fram. July 3 alive an any 9, 1960, and that death | 0, 1960, to acy 9 | , 160, that I last saw the deceased |
| / | ACTUAL SIGNATURE SIGNATURE SIGNATURE | ADDRESS (Street, c | |
| | PHYSICIAN'S F.P. Sun Joseph | m W. Ware | ungton md |
| 2 | Removal Specify August 3, 1960 MT | CREMATORY 224 LOCATION | City, Jown, or county) (State) |
| 23 | FUNGRAL DIRECTOR'S SIGNATURE PADDRESS : | Maraug 1 6 '60 | 24b. REGISTRAR'S SUNATURE |



VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09175

| | 1, PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
|---|---|--|
| | O. COUNTY HARFORD MARYLAND | O. STATE MARYLAND b. COUNTY CECIL |
| | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | HAVEE SE GRACE 36 DAYS | RD=1 |
| | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| | HARFORD MEMORIAL HOSP. | North East YES NO |
| | 3. NAME OF First / Middle / | Last 4. DATE Month Day Yeor |
| | (Type or print) John KAndolph | JANNEY JR DEATH HUGUST 7 1960 |
| | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 7-11- 1906 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| | MAIE WhitE WIDOWED DIVORCED | NEW JERSEY 54 YE. |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | SPECIAL AGENT INSURANCE | |
| 1 | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Λ | JOHN KANDOLPH JANNEY | TRANCES GALATION |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no. or un)mown) (If yes, give wor or dates of service) | Address Va |
| | No 136-09-8525 | John J. Janney 111 Charlottesville |
| | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | INTERVAL BETWEEN ONSET AND/DEATH |
| 4 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Ruftline and | nterventricular septum sudden |
| | TO DUE TO | 1 1 1 1 1 1 |
| 1 | Conditions, if ony, which) (b) Anewordman | - Interventricular Septum? |
| | gove rise to immediate couse (a), stating the under- | forting Dantoing wood and 36 day |
| | lying couse lost. (c) Myocardial, M | of the carry of th |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF ATTHEORY | PERFORMED? |
| | 5 | YES NO 🗆 |
| × | OR CONTRIBUTING LEAUSE OF DEATH | D. (Enter noture of injury in Port I or Port II of item 18.) |
| | | |
| | Hour o. B. While Not white fo | ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) ctory, street, office bldg, etc.) |
| 1 | p. m. 19 of work and work | |
| | 21. I certify that (I) (this haspital) attended the deceased fram | July 2 1960, to August 71960, that (1) (we) last |
| | saw the deceased alive an Aug 7/19 60 and that a | death occurred at 2 AM, from the causes and an the date stated above. |
| | 220. SIGNATURE | ATTENDING MED. STAFF STAFF |
| | alussa Colomo | M.D. PHYS. DIRECTOR PHYS. D |
| | 22c. PHYSICIAN'S NAME (Type) | 22d ADDRESS No Engre And |
| | Europe C. Loo, M | Diffavre de grace, me |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY C | R CREMATORY 23d. LOCATION (City, town, or Carty) (Stote) |
| | DURIAL 0-11-1960 BAY V | IEW METH NORTH EAST CECIL MU |
| 1 | 24. FUNERAL DIRECTOR'S SIGNATURE OD ADDRESS | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 1 | Joseph OT Trant north | saf MAPATE AUG 11 '60 Callun S. Kinus |

and the state of t THE LOND FOR THE BOTTOM STATE OF THE STATE O THE TANK IN THE PROPERTY OF THE PARTY OF THE AND THE PROPERTY OF THE PROPER AND THE WAY WAY YES AND THE

09176

| 0 / | | |
|-----|--|--|
| | | USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) D. STATE |
| | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c | c. CITY OR TOWN (If aetside corporate limits, write RURAL and give nearest town) |
| | HAURE OF GRACE 18DAYS | Rising Sun 07/- |
| 7 | OR INSTITUTION | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO |
| - | HARFORD MEMORIAL HOSP. | 110111 |
| | 3. NAME OF DECEASED (Type or print) E//is LE Roy Ja | ONES 4. DATE Month Day Year OF DEATH AUGUST 10 1966 |
| H | 11010 | TE OF BIRTH 9. AGE (In deors IF UNDER 1 YEAR IF UNDER 24 HRS. I |
| | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) | 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | during most of working life, even if retired) LABORER PAIRY | PENNSYLVANIA U.S.A. |
| B | 13. FATHER'S NAME | MOTHER'S MAINEN NAME |
| | HNOREW JACKSON JONES | MARY HACKINESHLEMAN |
| 1 | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORM 18. INFORM 19. | MANT Address |
| 1 | / 716 | m seles , orang sen. Mac |
| | 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] PART I. DEATH WAS CAUSED BY: | INTERVAL BETWEEN ONSET AND DEATH |
| | DUE TO DUE TO | |
| | Conditions, it ony, which) (b) Herd skin I | vacine questied |
| 0 | gove rise to immediate couse (a), stating the under | |
| 7 | lying cause lost. (c) | |
| 1 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? / YES NO [5] |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ster noture of injury in Port I or Port II of item 18.) |
| | 3 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE C | OF INJURY (Home, form, 20f. (City or town) (County) (State) |
| | Hour o. m. p. m. 19 While Not while of work of work | street, office bldg., etc.) |
| | 21. I certify that (I) (this hospital) attended the deceased fram | , 19, that (I) (we) last |
| | saw the deceased alive an 8 10 1960, and that death | |
| | 220. SIGNATURE / New Cl | ATTENDING MED. STAFF 22b. DATE |
| H | 22c. PHYSICIAN'S NAME (Type) | PHYS. DIRECTOR PHYS. 22d. ADDRESS |
| | (Type) | |
| | 23g. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CRE | MATORY 23d. LOCATION (City, town, or county) (Stote) |
| 1 | Bush 8/13/1860 Beach wine | Emeley String fun md. |
| X | 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 26. REC'D BY REGISTRARY 25b. REGISTRAR'S SIGNATURE |

the attending physician and completely filled in by the funeral director, Then please remave carban papers. Pages 1 and 2 should be filed with rs ofter death. Page 4 law requires that the death certificate be executed within 24 hz TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 on the State Board of Health prior to burial, cremation, or remaval, and in any creek within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN VR A15 (4) 15M 9/59

ASTER AFFECT A Family of files of 178 Pope of the Santa Art of the LASTER THE TAXABLE TO SELECT THE SECOND SECO INDICES SERVICES SERVES SERVER SERVER SERVER The to 1781 the type marks the training mark AND THE RESERVE AND THE PARTY OF THE PARTY O 是是一种理点的发生。1861年18日,是他们的现在分词,1861年18日,1861年18年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861年18日,1861 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attendid hysician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending the continual page 3 should be detached for the continual page 3 shoul

| | TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled many the funeral director, | page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon pagers and 2 shauld be sha | July / |
|---|---|--|--|
| | ned by the attending physician and | ermit. Then please remave carbon p | the registrar priar ta burial, crematian, ar remaval, and in any event within 72 haurs after death |
| affendit hysician. | ertificate has been sign | as the burial-transit pe | an, ar remaval, and ir |
| may be retained by the hospital or attendit hysician. | DIRECTOR: After this ce | ld be detached for use | priar ta burial, cremati |
| may be reta | TO FUNERAL | page 3 shaul | the registrar |

| MARYLAND | STATE DEPARTMENT | OF HEALTH—BALTIMORE, | 18 |
|----------|------------------|----------------------|----|
| 9215 | CERTIFICATE | OF DEATH | |

()9177

| | Reg. Dist. No. |
|--|--|
| 1. PLACE OF DEATH O. COUNTY HOWARD MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE b. COUNTY |
| b. CITY OR TOWN (If autside corporate limits, write RYRAL and give negrest town) RERAL 3 STERES | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION PORT | d. STREET ADDRESS Red Prings Road e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) By Tord E Middle | Kane OF Month Day Year DEATH Hugust 281960 |
| 5. SEX 6. COLON OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 7-31-64 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min. M |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prof. Friter CTV11 SETVICE | USTRY 11. BIRTHPLACE (State or foreign country) With County Norgania U.S. A. |
| Charles KANE | Elsie Meridith |
| 15. WAS DECEASEDEVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give wor or dates of service) (Yes, no or unknown) (If yes, give wor or dates of service) | INFORMANT (W: FE) INFORMANT (W: FE) BET ATT, MATTING |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate cause (o), stoting the under. lying couse lost. PART I. DEATH WAS CAUSED BY: (b) DUE TO Conditions, if ony, which gove rise to immediate (c) Conditions, if ony, which gove rise to immediate (c) Conditions, if ony, which gove rise to immediate (c) Conditions, if ony, which gove rise to immediate (c) Conditions, if ony, which gove rise to immediate (c) | envire disease ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CONTRIBUTIN | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES \[\] NO \[\] |
| | ED. (Enter nature of injury in Part I or Port II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED for the control of the | LACE OF INJURY (Home, farm, clary, street, office bldg., etc.) 20f. (City ar town) (County) (State) |
| M DIA DIO | h occurred at OL M, from the couses and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED |
| PHYSICIAN'S Gerald Cralmer PHYSICIAN'S Gerald Cralmer | MD. Befter, My 8-28-6 |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY O | OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) ORTAL GARDENS BEL APT, HATE, Co. MARYLAND |
| 23. EUNERAL DIRECTOR'S SIGNATURE W. Brondward ADDRESS WILL STORY | DATE AUG 3 1 60 CICHAN & TIME |

| | 43-011484-40 B | | | |
|----------------|----------------|-----------------------|------------------|--|
| | 210 | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| AN WALL STORES | Windows News | 101-142-168 | | |
| | | | | |
| 100 | etseMagne. | M | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | Annual III - 1979 - I | age Constitution | |

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09178

| | PLACE OF DEATH COUNTY Arford MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland COUNTY Description: Residence before admission) |
|---------------|--|
| k | c. CITY OR TOWN (If outside carporate finits, write c. LENGTH OF STAY IN 16 RURAL and give negrest town) Leves Leve Leve Leve Leve after 30 yrs. RURAL and give negrest town) |
| | d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION Have de Grace Levio Lane - General Relinency YES NO ST |
| | NAME OF DECEASED Corporation Concluded Lost Lost DEATH South Day Year DECEASED Type or print) Emily L. Zell DEATH 8 27 1960 |
| S. S | Female 7 Married Never Married 18. Date of Birth Female 7 Married Never Married 19. DIVORCED 19. DATE OF BIRTH Female 7 Months Days Hours Min. |
| 10a | USUAL OCCUPATION (Give kind of work dane lob. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Language of working life, even if retired) Language of the local state of the local |
| 13. | FATHER'S NAME Joe Johnson Laura Johnson |
| | WAS DECEMSED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17, INFORMANT Address Larris Large M. Robert Gather Fell Have delty Have delty of service) |
| | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urenia |
| | Canditions, if ony, which gave rise to immediate cause (a), stating the under DUE TO |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| MEDICAL | 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Haur a. m. p. m. 19 20d. INJURY OCCURRED County (State) PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) (County) (State) factory, street, affice bldg., etc.) |
| | 21. I certify that (I) (this haspital) attended the deceased fram July 11 , 1960, to Aug. 27, 1960, that (I) (we) last saw the deceased alive on Aug. 24, 1960, and that death occurred at 7:30 P.M., from the causes and an the date stated above. 220. SIGNATURE () 22b. DATE |
| | Leorge J. Stansbury M.D. ATTENDING MED. STAFF SIGNED 22c. PHYSICIAN'S 22d. ADDRESS 22d. ADDRESS |
| | NAME (Type) George T. Stansbury 569 Revolutionst. Howard Grow, maryland |
| | BURIAL CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) Burial 8-30-1960 Uprion Methodist Com. Werden. Md. |
| 24. | FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Orihun S. Krause ADDRESS AD |

HYLASH TO THE MODIA TERMENTS OF A STATE OF THE REAL PROPERTY AND ADDRESS OF THE PARTY O 25 100 9136

| * := (| | | 9197 | CERTIFICA | ATE OF DEATI | H | 09179 Reg. Dist. No. |
|--|---|---------------|--|---|--|---|--|
| director filed with | | | PLACE OF DEATH b. COUNTY Harford | MARYLAND | 2. USUAL RESIDENCE (WO O. STATE | here deceased lived. If institution b. COUNTY | Residence before admission) Harford |
| offer death. | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (IF | outside corporate limits, write RUI | RAL and give nearest town) |
| 77 | 1 | | d. NAME OF HOSPITAL (If not in hospital, give stree OR INSTITUTION Harford Memorial | Hospital | d. STREET ADDRESS 211 I | erlington Av | e. IS RESIDENCE ON A FARM? YES NO (A) |
| ithin 24 hour | | - | NAME OF First DECEASED (Type or print) KATHY | Middle NOREEN | KELLY | 4. DATE Month OF DEATH AUGUS | |
| \$ 0 | | 5. S | Female White widow | VED DIVORCED | 8. DATE OF BIRTH Sept. 12, | 1956 3 yrs. | F UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min. |
| ond cample bon papers. | 1 | | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | NA | Mary | land | U.S.A. |
| ag in in in | | | Glenn R. Kel | | | Nelson | |
| h certifica ing physic se remove 72 hours | | 15. (Yes | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. no. or unknown) (If yes, give wor or dates of service) NO | | NFORMANT lenn R. Kel | .ly, 211 Darl | Aberdeen, Md. ington Ave. |
| iquires that the deat n. signed by the attend t permit. Then plea d in any event withii | | | 18. CAUSE OF DEATH [Enter only one couse per I PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if only, which gove rise to immediate couse (o), stating the under- lying couse lost. | line for (0), (b), and (c).] | ymphati. | Lenkeme | INTERVAL BETWEEN ONSET AND DEATH MONTH |
| direction, and a second of the | 0 | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS | CONTRIBUTING TO DEATH BUT | | | N IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO X |
| tol or attention or use as the certification or use as the creation, a | | | 20c. TIME OF INJURY Month, Day, Year 20d. Hour o.m. White | Not while of work | ACE OF INJURY (Home, form tory, street, office bldg., etc | 20f. (City or town) | (County) (State) |
| ATTENDING by the haspi store. TOR: After detached for to buriol, or | / | | 21. I certify that I ottended the deceo alive an | | accurred atl:15 | ADDRESS (Street, city or town, ste | Pa |
| SPITAL OR. De retained like AL DIRECT 3 should be gistrar prior | | | SIGNATURE 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | unkett Jr. | M.D. Abe | W. Bel Air ordeen. Md. | Ave. <u>X-11-b</u> |
| O HOSPITAL may be retain O FUNERAL I page 3 shoul the registrar | 0 | | BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 8/13/60 | 22c. NAME OF CEMETERY OF Bel Air Mem | orial Garde | 22d LOCATION (City, town, or ns, Bel Air | |
| VS A15 (4) 15M 10/57 | 2 | 13. | John G. Tarring | ring Funeral Aberdeen, M | Home 240. REC | | RAR'S SIGNATURE |

MADYLAND STATE DEPARTMENT OF HEALTH DALTIMODE TO

| at at an | OF HEALTH-BALTIME | AS COMPANIED TO A 12 OF | farryam - | |
|--|--|-------------------------|--------------------|---|
| | HTASO TO B | | CAU | |
| | And the second | | 71 No. 1 | |
| | BANK TO THE REAL PROPERTY. | | ·n | |
| | | | | |
| The state of the state of | | | | |
| | name | | | |
| • • • e | | | | |
| | | | A CHIEF CO. | 1 |
| | 115 . Tile C. B. Day | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| en e | And the state of t | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | and year at a more | |

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9217 CERTIFICATE OF DEATH

09180

| | | 17 | U | Ji. | (|
|-----|------|----|---|-----|---|
| 200 | Dies | Na | | | |

| 1. | PLACE OF DEATH o. COUNTY H | ARFORD | | MARYL | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY HARFORD | | | | | mission) | | |
|-----------------|---|--|-------------------|-------------------------------------|--|--|-------------------------|---|--------------|-------------|-------------------------------------|--|
| | b. CITY OR TOWN (If RURAL ond give ne | outside corporate limi arest town) | ts, write | c. LENGTH OF STAY IN | V 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| L | DARLING | TON R | ral- | LIFE | | | NGTON | | Ru | ral | | |
| L | OR INSTITUTION | AL (If not in hospital, g | jive street | address) | 1 | d. STREET ADDRE | SS | | | 0 | RESIDENCE N A FARM? | |
| 3. | NAME OF DECEASED (Type or print) | Fir PΔΙΙΤ. | st | Middle RUFUS | P | Losi | 4. DATE OF DEATH | Moi | nth 5/ | Day | Year 19 60 | |
| 5. | SEX | | 7. MARR | IED NEVER MARRIED | | ATE OF BIRTH | | 9. AGE (In years | IF UNDER | I YEAR IF U | NDER 24 HRS. | |
| | MALE | WHITE | WIDOWE | DIVORCED | 0 1 | 7/ 24/ | 1001 | lost birthdoy) 58 yrs. | | Days Ho | urs Min. | |
| 10 | during most of work | N (Give kind of work ing life, even if retired | done 10b. | KIND OF BUSINESS OR | INDUSTRY | 11. BIRTHPLACE (| State or foreign o | country) | 12. CITI | ZEN OF W | HAT COUNTRY | |
| | | EADER | 1 | J.S. GOVE. | | HARFOR | RD CO. | MD. | U. | S.A. | | |
| 13. | FATHER'S NAME | | | | 1. | . MOTHER'S MAID | EN NAME | | | | | |
| al | HUGH H | KNIGHT | | | | SARA | JANE | TROUTNE | R | | | |
| | WAS DECEASED EVER | IN U. S. ARMED FOR | | SOCIAL SECURITY NO. | 17. INFO | THAME | | | dress | 11111 | | |
| L | NO | | 12 | 18-05-1582 | MRS | RESSI | E KNIG | HT DA | RLING | TON. | MD. | |
| | | TH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO Ty, which (b) Immediate | (4) | Grand (c). J. | ani ruha | I lte | tack | · · | | | BETWEEN ND DEATH | |
| Z | PART II. OTH | ER SIGNIFICANT CON | DITIONS C | ONTRIBUTING TO DEAT | H BUT NOT | RELATED TO THE T | ERMINAL DISEAS | SE CONDITION GI | VEN IN PART | 1(o) 19. W | AS AUTOPSY | |
| LA D | | | | | | | | | | | RFORMED? | |
| A CERTIFICATION | | S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER) |) | CRIBE HOW INJURY OCC | en . | | | | | | | |
| MEDICAL | 20c. TIME OF INJURY Hour o. 51. p. m. | Month, Day, Yes | While | Not while . | Oe. PLACE foctory. | OF INJURY (Home, street, office bldg. | form, 20f. (City, etc.) | y or town) | (Co | ounly) | (Stote) | |
| | 21. I certify the alive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | at I attended the | decease , 12 k | and they are and they are as a mark | eath occ | Urred and | | the causes of the courses of the courses, city or town, | and on th | | he deceased ated above. DATE SIGNED | |
| 22 | BURIAL, CREMATION | N, 22b. DATE THEREC | FV | 22c, NAME OF CEMET | ERY OR CR | EMATORY | 22d. LOCA | TION (City, town, | or county) | (| Stote) | |
| L | Burial | 18/19/19 | 960 | DARLING | CON | CEM. | DARL | INGTON | | | MD. | |
| 23. | FUNERAL DIRECTOR'S | SIGNATURE | 11 | ADDRESS | | | REC'D BY REGIS | TRAR 245. REGI | STRAR'S SIGI | NATURE | | |
| | rement. | 111-114 | elle. | ~ RISING | SUN. | MD DATE | AUG 18 | '60 | 11 0 | + . | | |

the state of the s and the second part of the second frame Val. 1991 Second and the second Jane France France Son.

HEALTH DEPT please execute the certificate, writing the word "pending" in fem 18. Give Peges 1, 2, and 70 the teacher. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 facts before relating for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-fransit permit. File pages 1 and 2 with me State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hour, after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

O 1 0 0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

O 1 0 4

| | 1100 Items 3.13.14 Fil | m(1)70 0 6 6 | 0-04 | 113101 |
|---------------|--|--------------------------------|---|--------------------------------------|
| | LACE OF DEATH | 2. USUAL RESIDENCE | (Where deceased lived, If institution: | Residence before edmission) |
| - | Harterd MARYLAND | a. STATE Med | b. COUNTY | roll |
| Ь | CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If o | outside corporate limits, write RURAL an- | d giva naarast town) |
| | write RURAL and give neerest town) | 11 | illena | |
| d | NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | | . IS RESIDENCE |
| j | OA Harford Memorio PHospetal | d. Jines Appress | 06X- | ON A FARM? |
| | Peceased P First Middle Matth | esus, Last | DATE Month | Day Year |
| (| (ype or print) (usell) | MARKET | DEATH MIGH. | 7, 1960 |
| 5. 5 | EX 6. COLOR OR RACE 7. MARRIED WEVER MARRIED 8. | DATE OF BURTH | 9. AGE (In year OF UNDER 1 | YEAR IF UNDER 24 HRS. |
| | WIDOWED DIVORCED DI | 7/4/04 | last birthday) Months | Days Hours Min. |
| 10a. | USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or | | TIZEN OF WHAT COUNTRY? |
| don | during most of working life, even if refired) | 1/1 | 4 | 150 |
| 12 | FATHER'S NAME | VA, | LI CI | .5.//. |
| 13. | FAIRER 2 NAME | 14. MOTHER'S MAIDEN NA | · · | |
| | Lee Alexander Matthews | Mannie Wall | ker | |
| | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN no, or unkown) (Ifyes give were detes of service) | IFORMANT | Address | |
| , , , , , | 218-01-2857 | | | |
| 1 | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | - 1 | | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fraction | kull | | ONSET AND DEATH |
| | / d/- / / | | | |
| 1 | DUE TO | | | |
| | Conditions, if eny, which (b) | | | |
| | (a), steting the underlying DUE TO | | | ALVAIS |
| | cause lest. (c) | | | |
| NO | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT | RELATED TO THE TERMINA | L DISEASE CONDITION GIVEN IN PART | T 1(a) 19. WAS AUTOPSY PERFORMED? |
| | | | | YES NO |
| CERTIFICATION | 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (En | ter nature of injury In Pa I | or Part 11 of item 18.) | |
| T. | PRIMARY To or CONTRIBUTING A MTO accur | den | | |
| MEDICAL | A | E OF INJURY (Home, farm, | 20f. (City or town) (Cou | unty) (State) |
| VED | Hour S.m. 8-2919 While Not While Rector | y, street, office bldg., etc.) | Fullslon Ha | where we |
| - | 21. I certify that I took charge of the remains described above, held | an Autopsy . In | spection , Inquiry , | and in my opinion |
| | death resulted from: Natural causes . Accident . Suicid | | Undetermined manner | 7 |
| | death resulted from: Natural causes, Accident, Suicident | | - D 11 | |
| | Yes old to talman | CHIEF MEDICAL EXA | | |
| | SIGNATURE SIGNATURE | M.D. ASSISTANT MEDICA | AL EXAMINER [| DATE SIGNED |
| | EXAMINER'S Gerold (Polmer) | M 1) DEPUTY MEDICAL E | | 8-29-66 |
| | BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR | | 2d. LOCATION (City, town, or country | (State) |
| | REMOVAL Specify 9/2/40 BALLIMORES | [Emistery | BALLIMORE | MD |
| | FUNERAL DIRECTOR ADDRESS | | BY REGISTRAR 246. REGISTRAR'S S | IGNATURE |
| 1 | F Francis Orden Hunton | DATE SE | P 1 '60 arthur 1 | 8. Krana |
| L | 11 FRANZ JOH 880 F JAKKIOKH | DATE DATE | | |

50 - 0 CH . 1 the second and the second seco The state of the s

LAND STATE DEPARTMENT OF HEALTH **BALTIMORE 1. MARYLAND** RECORDS, 301 **EXAMINER'S CERTIFICATE OF** 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) PLACE OF DEATH a. COUNTY director. Page a. STATE is necessary MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside cosporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS for . IS RESIDENCE ON A FARM? be refained YES NO 3. NAME OF Middla DATE Month Year DECEASED in pencil in Hem 18. Give Pages 1, 2, and 3 to the OF (Type or print) DEATH with 6. COLOR OR RACE 5. SEX 8. DATE OF BIRTH IF UNDER 24 HRS 9. AGE (In years | IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED may and 2 m last birthdey) Months Days Hours WIDOWED DIVORCED 24 hours after 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Page done during most of working life, even if retired) pages form PM3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME File certificate should be executed within 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yas, no, or unkgwn) | (If yesgiva war or dates of servical permit. Office along with burial-transit perm 18. CAUSE OF DEATH [Entar only one cause per line for (a), (b), and (c). INTERVAL BETWEEN . = ONSET AND DEATH PART I. DEATH WAS CAUSED BY: and IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) lease execute the certificate, writing the word "pending" should be forwarded to the Chief Medical Examiner's C FUNERAL DIRECTOR: Page 3 should be used as a b gave rise to immadiate cause DUE TO (a), stating the undarlying 9 cause lest. cremation, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTORSY CERTIFICATION PERFORMED? NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enler nature of Injury in Part I or Part II of itam 18.) PRIMARY [] or CONTRIBUTING [urial. DEPUTY MEDICAL EXAMINER CAUSE OF DEATH. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Homa, farm, : 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year (County) (State) factory, street, office bldg., atc.) 0 Whila Not While Hour a.m. at work at work prior 21. I certify that I took charge of the remains described above, held an Autopsy Inspection agent, Natural causes Suicide death resulted from: Accident Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE D DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) ddrass (Streat, city, town, or county) 22a, SURIAL, CREMATION, 22b. 22c. NAME OF CEMETERY OR CREMATORY DATE THEREO! LOCATION (City, towp, or country (Stata) REMOVAL (Specify) OL 40 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR 24. REC'D BY REGISTRAR VS. A15ME 5M 7/59 DATE AUG 2 2 '60

Day

Doys

(County)

25b. REGISTRAR'S SIGNATURE

aller & Hours

25g. REC'D BY REGISTRAR

DATE 1 5 '60

e. IS RESIDENCE

ON A FARM YES NO

Yeor

19

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stote)

22b. DATE SIGNED

(Stote)

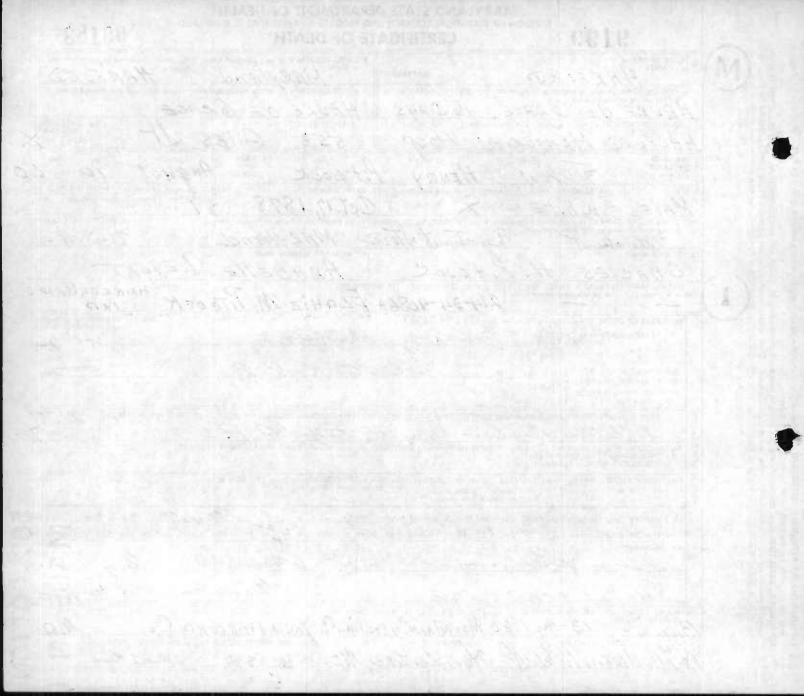
12. CITIZEN OF WHAT COUNTRY?

9199 CERTIFICATE OF DEATH of director, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND the funeral should be fi CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) RACE d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS INSTITUTION puo NAME OF 4. DATE Last DECEASED campletely filled DEATH Pages death. (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE MA yeors ofter : lost birthdoy) Months WIDOWED DIVORCED YES 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS during most of working life, even if retired) pup pou 72 13. FATHER'S NAME 14. MOTHER'S MAINEN NAME COL physician 2 remove Address 17. INFORMANT attending pleose any 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o the DUF TO Conditions, if ony, which permit. emaval (b) gned gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. burial-transit 20 heen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY hos 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW-INJURY OCCURRED. (Enter notice of injury in Port I or Port II of item 1B.) certificate the (IF EITHER, NOTIFY MEDICAL EXAMINER) OS 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Month. Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) USe Hour o.m. While Not while 0 of work of work p. m. detached far prior 1969, to this 10, 1960, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. M, from the causes and an the date stated above. , and that death accurred at 4 saw the deceased alive an FUNERAL DIRECTOR: 22o. SIGNATURE ATTENDING STAFF pe M.D. PHYS. DIRECTOR | PHYS. 22c PHYSICIAN'S 22d. ADDRESS 3 should NAME (Type) 0 23d. LOCATION (City, town, or county) 23a. BURIAL, CREMATION. page the Sta

10

VR A15 (4) 15M 9/59

24. FUNERAL DIRECTOR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09184 CERTIFICATE OF DEATH 9184 Reg. Dist. No. filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND Harford Varyland Harford b. CITY OR TOWN (If outside corporate limits, write after death. C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) pe RURAL and give negrest tawn) P berdeen Aberdeen d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION YES NO TH Dorsey Street Dorsey Street 4. DATE 3. NAME OF Fhat X Middly TON DECEASED DEATH (Type or print) Fred G. Pitt (Frederick Pitts) August IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthday) Colored WIDOWED D DIVORCED T Feb. yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) Laborer Maryland TI.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Catherine Stansbury James Albert Pitt IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17, INFORMANT Address Box /13 -A John Pitt. R.D. 1, Havre de Grace. Md. 18. CAUSE OF DEATH [Enter anly one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? monary luberculosis E 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW/INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) ar 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) (County) (State) factory, street, affice bldg., etc.) Haur a. m. Nat while at wark at wark July 11, 1960, to AUS.19 1960 that I last saw the deceased 21. I certify that I attended the deceased fram, 19 40 , and that death accurred at 2:00 RM from the causes and on the date stated above. alive on ADDRESS (Street, city or town, state) DATE SIGNED Revolution St 0 FUNERAL D PHYSICIAN'S de Grace, Md. Stansbur v. NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or county) REMOVAL (Specify) Md. Union Methodist Cem. R.D. Aberdeen. Burial 24b. REGISTRAR'S SIGNATURE 23. FUNERAUDIRECTOR'S SIGNATURE Tarrin Doressuneral Home 24g. REC'D BY REGISTRAR VS A15 (4) DATEUG 2 3 '60 Aberdeen, Md. 1SM 10/57 Tarri John

per state and replace makes will and TVL CCC To be any common of the first CCC to the ofter death.

within 24

| \$1,780 MI | | | | |
|----------------------------|--|--|----------------|--|
| | | | | |
| | | | | |
| | | | bro trail | |
| | | | | |
| *** | | | | |
| | | | | |
| | | | | |
| | | | | |
| ENGLISHED SPECIFICATION OF | | Comment of the control of the contro | | |
| | 2-2-2-22-22-27-11 | | | |
| | forms parious | 0.020 | 201.55 | |
| | their crussian | | oca s mad | |
| IE T. T. C. AV. & DO. | | | | |
| lo est ter of | rot region. | | | |
| | | TO SEE STREET | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Street, Street | |
| | | | | |
| | | | | |
| | | THE CONTRACT | | |
| | The Contract of the Contract o | ale with a right | | |
| or to the contract | | | | |
| | | | | |
| | | evono del | | |
| | | Farehold - and Indian | | |
| | | | | |
| | | | | |

| - | 1. PLACE OF DEATH : day Lay Lay MARYLAND | a. STATE b. COUNTY Last Manual Country |
|---|---|--|
| - | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| 1 | d. NAME OF HOSPITAL OF not in respital, give street address) OR NATITUTEN Last Fred Manual Daspulal | d. STREET ADDRESS 718 Kevalution Street ON A FARM? YES NO D |
| | 3. NAME OF DECEASED (Type or print) Helen P. | Powell A. DATE OF Manth Day Year DEATH Clug. 2, 1960 |
| | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED | B. DATE OF BIRTH 3 / 16 / 1901 9. AGE (In yelds lift UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min. |
| | 100 USUAL OF CUPATION (Give kind of work dane during most of working life, even if retired) Kallel wife HOUSE WIFE | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Wassachusetts 12. CITIZEN OF WHAT COUNTRY? |
| | 13. FATHER'S NAME Hally - | Julia Hickey |
| | 15. WAS DECEASED EVER IN U. S. ARMED PORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no. or unknown) (If yes, give wor or dotal of service) (Yes, no. or unknown) | Pary C. Baker - suster in law |
| | 18. CAUSE OF DEATH [Enter only one couse per line for/(o), (b), ond (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | INTERVAL BETWEEN ONSET AND DEATH 2 |
| | Condition if any which | ie Jayline, roll |
| | gove rise to immediate couse (a), stoting the under-lying couse lost. (b) DUE TO (c) (d) | Curtic Heart duran I week |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NOW |
| | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ED. (Enter nature of injury in Part I or Port II af item 18.) |
| | | LACE OF INJURY (Home, farm, octory, street, office bldg., etc.) (City or town) (Caunty) (State) |
| | 21. I certify that (I) (this haspital) attended the deceased fram. saw the deceased alive an assets. 1960, and that | death accurred at 73 M, from the causes and an the date stated above. |
| | Enant. Wa Iman | M.D. ATTENDING MED. STAFF DIRECTOR DIRECTOR PHYS. D |
| | 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRøss |
| | 23g. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR BURIAL (Specify) | OR CREMATORY 23d. LOCATION (City, toyn, or county) (Stote) |
| | 24. PONTRAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS AND LINE ADDRESS ADDRESS AND ALLE | 25g. REC'D BY REGISTRAR & 25b. REGISTRAR'S SIGNATURE DATEAUG 4 '60 Chilling 8. Kinna |

TO HOSPITAL OR ATTENDING PHYSICIAN: Now requires that the death certificate be executed within 24 hours offer death. Page 4 may be remained by the hospital or attending yisician.

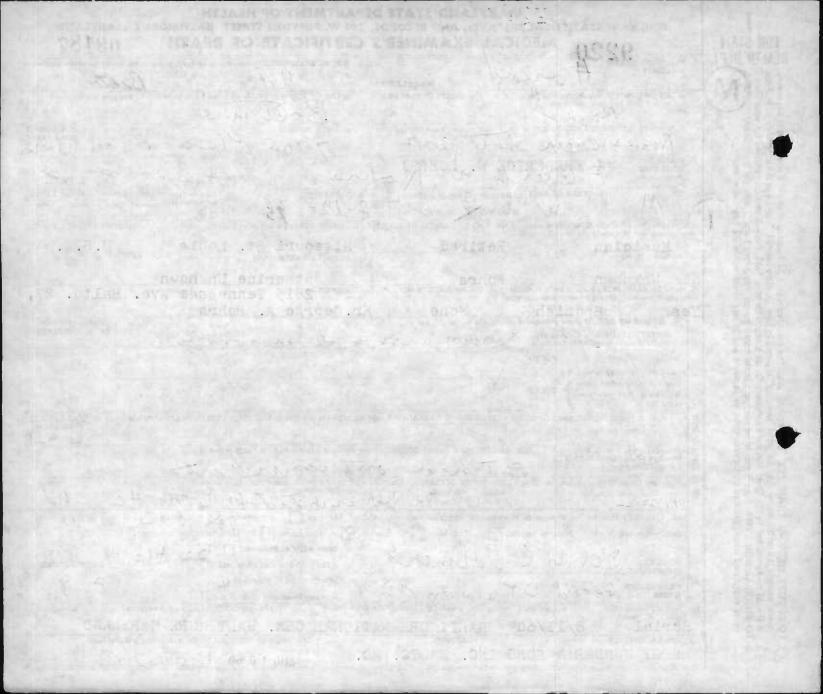
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in ay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with the State Board of Health prior to burial, cremation, ar remayal, and in any evint, within 72 haurs offer death.

VR A1S (4) 1SM 9/59

The state of the s

301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Division of STATISTICAL RESEARCH AND RECORDS. MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY rifficate should be executed within 24 hours after death. If any y is necessary, "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page xaminer's Office along with form PM3. Page 5 may be retained for your files. used as a burial-transit permit. File pages 1 and 2 with the State Board of receipt, ion, or removal, and in any event within 72 hours after death. a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate fimits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL end give neerest town) d. NAME OF HOSPITAL OR INSTITUT IS RESIDENCE ON A FARM? YES NO NAME OF DATE DECEASED OF (Typa or print) 196 DEATH 5. SEX 8. DATE OF BIRTH AGE (In Years | IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthdey) Months House Min. WIDOWED DIVORCED USUAL OCCUPATION (Give kind of work BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Missouri St. Louis Musician Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Catherine Unknown Ilnknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 2815 TennessééresAve. 17. INFORMANT (Yas, no, or unkown) | (If yes give war or dates of service) Spanish None 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) please execute the certificate, writing the word "pending" 4 should be forwarded to the Chief Medical Examiner's CO FUNERAL DIRECTOR: Page 3 should be used as a be geve rise to immadiate cause DUE TO (e), stating the undarlying causa last. (c) PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19. WAS AUTOPSY CERTIFICATION PERFORMED? cremat NO D 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of Item 18.) PRIMARY IN OF CONTRIBUTING burial, DEPUTY MEDICAL EXAMINER: CAUSE OF DEATH. 20e. PLACE OF INJURY (Homa, farm, 20f. (City or town) 20c. TIME OF INJURY Month, Dey, Year 2Dd. INJURY OCCURRED (State) (County) fectory, stpeet, offica bldg., atc.) Not While prior to et work et work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide X Homicide Undetermined manner CHIEF-MEDICAL EXAMINER designated DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER T NAME (Type) Address (Street, city, town, or county) 22a, BURIAL, CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Spacify) 0 Burial 60BALTIMORE BALTIMORE CEM. 23. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VS. A15ME BALTO. SONS TNC. 5M 7/59 DATELUG 1 0 '60 arthur & Thous

MARYLAND STATE DEPARTMENT OF HEALTH



CH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) PLACE OF DEATH Page a. COUNTY e. STATE b. COUNTY HARFORD Harford MARYLAND b. CITY OR TOWN (if oulside corporele limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate fimils, write RURAL and give neerest town) write RURAL end give nearest lown) Havre de Grace Havre de Grace al direc S d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS Por e. IS RESIDENCE ON A FARM? retained Harford Memorial Hospital Webster Village YES NO K State es 1, 2, and 3 to the fune Page 5 may be retained 1 and 2 with the State n 72 hours after death. NAME OF Middle 4. DATE Year DECEASED (Type or print) DEATH JAMES SHIME 19 August 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days House Male White WIDOWED [DIVORCED Sept. 10a, USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY I 11. BIRTHPLACE (Slete or foreign country) 12. CITIZEN OF WHAT COUNTRY? "pending" in pencil in Item 18. Give Pages 1, 2 xaminer's Office along with form PM3. Page done during most of working life, even if retired) File pages 1 U.S.A. Child Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Philip J. Shimek
15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIA Elizabeth Kilburn event 16. SOCIAL SECURITY NO. | 17. INFORMANT Address R.D. 2 permit. (Yes, no. or unkown) | (If yes give wer or deles of service) Office along with family burial-transit permit amoval, and in any e Havre de Grace, Philip J. Shimek rtificate should be executed 18. CAUSE OF DEATH |Enter only one cause per line for (e), (b), end (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY Asphyxiation due to aspiration of foreign body. IMMEDIATE CAUSE (e) removal, DUE TO Conditions, if eny, which (b) gave rise to immediate causa Examiner's (0) DUE TO (e), stating the underlying 98 0 cause last. should be used cremation, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(m) 19, WAS AUTOPSY CERTIFICATION PERFORMED? lease execute the certificate, writing the work should be forwarded to the Chief Medical PUNERAL DIRECTOR: Page 3 should b r its designated agent, prior to burial, cremi NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. DEPUTY MEDICAL EXAMINER: Aspirated foreign body Harford Md. 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm,) 20c. TIME OF INJURY Month, Day, Yeer 20f. (Cily or town) (County) (State) fectory, street, office bldg., etc.) While Not While at work et work street Havre de Grace Harford Md. 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Accident XI, death resulted from: Natural causes Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE August 18, 1960 DEPUTY MEDICAL EXAMINER EXAMINER'S William Lovitt. V. MaD. NAME (Type) Address (Street, city, town, or county) 220. BURIAL, CREMATION, 225. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stete) REMOVAL (Specify) 0 40 0 Burial Holy Redeemer Cemetery, Baltimore, Tarring^DPuneral Home Aberdeen, Md. 23. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE VS. A15ME AUG 23 '60 alley & Kraus 5M 7/59 John G. Tarring

MARYLAND STATE DEPARTMENT OF HEALTH

ACTION. To brillian erven de de les de l'entre d separation of to appreciation of fereign cody, By I have to Med. Exam.: Yellow cap- lashed like point of fishing tackle 8/25/60 - a.m.s. b brolles came convey control , Taylor , V main and the The same state of the same sta

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9202 CERTIFICATE OF DEATH

Reg. Dist. No. 189

| | FORD | | MARYLAND | 2. USUAL RESIDENCE (Was a. STATE | here deceased | l lived. If institution b. COUNTY | CEC | | ission) |
|---|---|---|---|---|---------------------------------------|-----------------------------------|--------------------|--------------------------------|--|
| b. CITY OR TOWN RURAL and give r | (If outside carporate limit | ts, write c. Lf | ENGTH OF STAY IN 16 | c. CITY OR TOWN (IF | autside corpo | rate limits, write R | URAL and g | give nearest to | wn) |
| HAV de | GRACE | | 1 DAY | CONOWING | 3O | I | RURAL | J | |
| d. NAME OF HOSPI OR INSTITUTION HARF | | | HOSP. | d. STREET ADDRESS | 1 | 77- | 7 | ON | RESIDENCE A FARM? |
| NAME OF DECEASED | Firs | st | Middle | Last | 4. DATE | Mon | th | Day | Year |
| (Type or print) | ROY | | LEE | THOMPSON | DEATH | 8 | 3/ | 3/ | 1960 |
| SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 1 YEAR IF UN | |
| MALE | WHITE | WIDOWED [| DIVORCED 🗍 | 12/ 9/ 18 | 95 | 64 yrs. | monins | Days Hou | rs Min. |
| during most of wa | ON (Give kind af wark d rking life, even if retired) DRIVER RE | Tane 10b. KIND | | JSTRY 11. BIRTHPLACE (State VA. 14. MOTHER'S MAIDEN | | ountry) | | S. A. | AT COUNTRY |
| COME. | Y THOMPSON | T | | MARG. | ARET | MUNCY | | | |
| | ER IN U. S. ARMED FOR | CES? 16. SOCIA | AL SECURITY NO. 17. | INFORMANT | LET CHAIL | Addi | ess | | |
| es, no, or unknown) | (If yes, give wor or dates of se | ervice) | | MRS. FRANCE | S THOM | MPSON (| COMO | WINGQ | (I) |
| Canditians, if gave rise to cause (a), stating lying cause last | immediate DUE TO |) | aplalic o | ment for | ~ CON | umma | 2) Olm | 1 Chr | Mac |
| A many land | | | KIBOTING TO DEATH BO | T NOT RELATED TO THE TERM | AINAL DISEASI | E CONDITION GIV | EN IN PAR | PER | FORMED? |
| OR CONTRIBUTING | AS UNDERLYING G CAUSE OF DEATH OF MEDICAL EXAMINER) | 20b. DESCRIBE | | T NOT RELATED TO THE TERN | | | EN IN PAR | PER | S AUTOPSY FORMED? |
| 20a. ACCIDENT WOR CONTRIBUTION (IF EITHER, NOTIF) 20c. TIME OF INJUINED IN THE PROPERTY OF THE PROPERTY OF THE P. M. | G CAUSE OF DEATH | or 20d. INJURY | HOW INJURY OCCURRING Y OCCURRED Rot while 20e. P | | Part I or Part | t II of item 18.) | | PER | FORMED? |
| 20c. TIME OF INJU Hour a. n. p. m. | G CAUSE OF DEATH (MEDICAL EXAMINER) RY Month, Day, Yea | or 20d. INJURY While at work | HOW INJURY OCCURRING TOCCURRED 20e. Place of work 1 | ED. (Enter nature of injury in LACE OF INJURY (Hame, for actory, street, office bldg., et | m, 20f. (City c.) M, fram ADDRESS (St | or town) | that I ind an ti | PER YES County) | (State) (State) The decease ated above |
| 20c. TIME OF INJU Hour a. jn. p. m. 21. I certify t alive an ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) | CAUSE OF DEATH MEDICAL EXAMINER) RY Month, Day, Yee 19 hat I attended the S ON, 22b. DATE THEREO | or 20d. INJURY While at work deceased fr | HOW INJURY OCCURRING TO OCCURRED 20e. Plant for at work 10 for at | LACE OF INJURY (Home, far actory, street, office bldg., et accurred at) | m, 20f. (City c.) M, fran ADDRESS (St | or town) | that I (ind an it) | County) last saw the date sta | (State) |

VS A15 (4) 15M 9/55

| 6410 | | | | SUNG. |
|---------------------------|--------------------------|---------------|----------|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| and the same of | | 1 A 2 . 1 . 1 | | |
| | | | | |
| and district | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | Levistic and below to them yether 1 Jil. 237 Sept. Sep |
| | | | | |
| | | 178149.77 | | |
| STANCE THAT IS NOT BEEN A | LICE OF STREET, IN COLUM | | Andrew . | STORY OF THE SHARE |

e. IS RESIDENCE

YES NO

Hours

INTERVAL BETWEEN ONSET AND DEATH

(-10 min.

PERFORMED? YES NO MY

12. CITIZEN OF WHAT COUNTRY?

ON A FARM

Yeor

19 60

09190

Rea. Dist. No.

Day

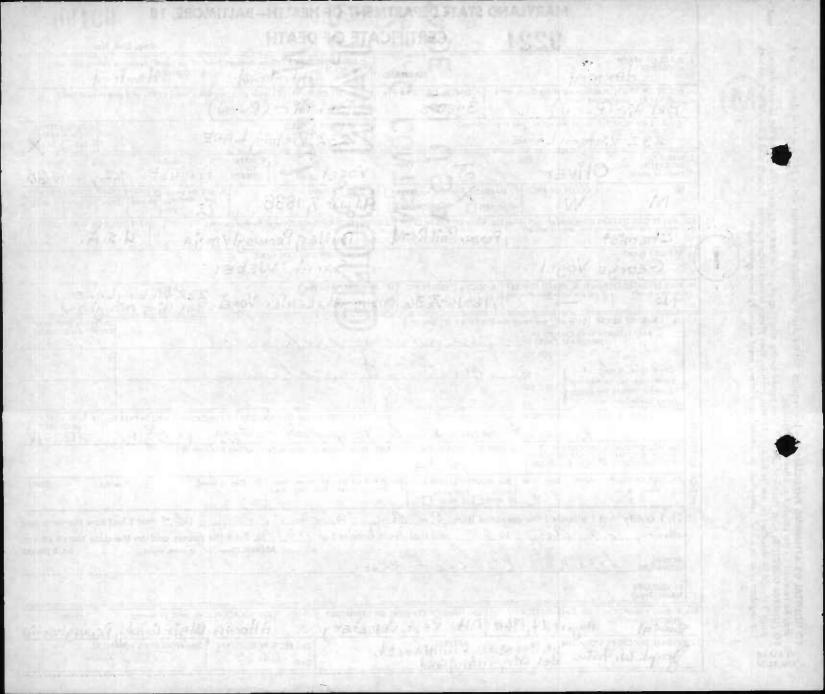
22

Doys

| O (IF EITH | ER, NOTIFY MEDICAL | EXAMINER) | NA | | | | | | |
|--------------|---------------------------------------|--------------------|--|---|-----------------------------|-------------------|---------------------|----------|---------|
| | E OF INJURY Monti our o.m. p.m. | h, Day, Year 19 | 20d. INJURY OCCURRED While Not while of work of work | 20e. PLACE OF INJURY (I foctory, street, office | Home, form, bldg., etc.) | 20f. (City or tay | vn) | (County) | (State) |
| 21. I dalive | TURE WAR | nended the d | | death occurred at | 1159 | M, fram he | causes and o | | |
| REMOY | AL (Specify) Au | / | 960 Alto REST | ETERY OR CREMATORY | | A HOCATION (| City, town, or coun | 4 | (State) |
| 23. FUNERAL | ph W. Frater | BEI A | andway ADDRESS High | us 24, | | BY REGISTRAR | 24b. REGISTRAR'S | | |
| | | | | | | | | | |

TO HOSPITAL 0 VS A15 (4)

15M 10/57



09191

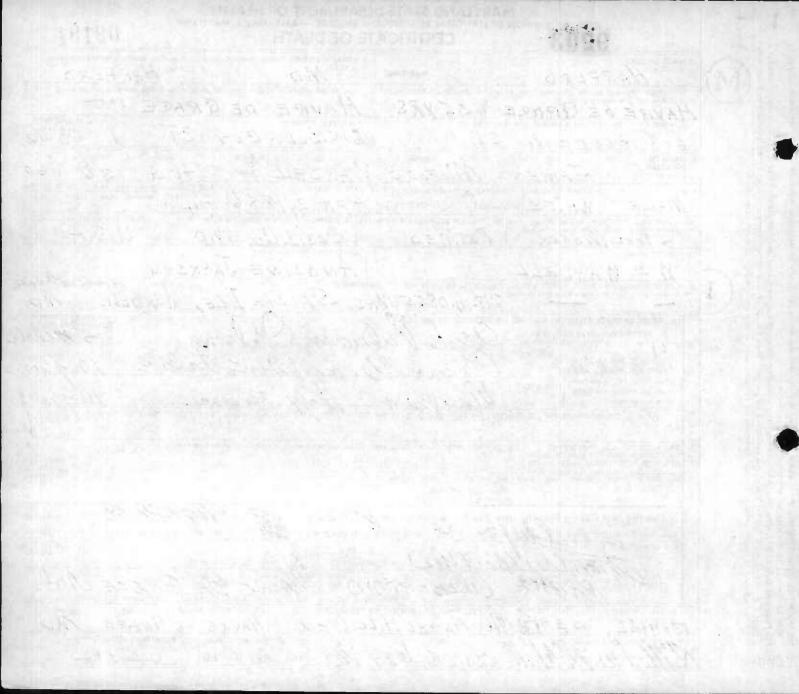
| 1. | PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |
|--------|---|---|
| | O. COUNTY HARFORD MARYLAND | O. STATE MD b. COUNTY HARFORD |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) |
| | HAVIRE DE GRACE 35 XRS | HAVIPE DE GRACE |
| | d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION | d. STREET ADDRESS o. IS RESIDENCE ON A FARM? |
| | 618 BOURBON SI | 16/8/2001 BON 21. 1 YES NO 18 |
| 3. | NAME OF First Middle | Last 4. DATE Month Day Year |
| | (Type or print) VAMES //ILFORP | WARDELL DEATH AUG 38 1960 |
| S. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| | NIALE WHITE WIDOWED DIVORCED | 17 PR. 3, 1889 74 yrs. |
| 10 | Oo. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | STEEL WORKER RETIRED | CECILGO, MP U.S.A. |
| 13 |). FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| 1 | XV - WARDELL | HNGLINE JACKSON |
| 15 | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II | NFORMANT Address MARREDEGRAG |
| 4 | - K-18-14-0833 /// | RS, DALLIELLEY WARDELL MD. |
| | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) | Imman Helsma 5 Minn |
| | 722, 2 DUE TO 11 . 1 | 1 1st - Fin a land |
| | Conditions, if ony, which gove rise to immediate (b). | listantine Tasure 10 year. |
| | couse (o), stoting the under- | 8 SI to |
| 7 | lying couse lost. (c) Well (Mary | Hyperlenseen 10 year. |
| CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? |
| FICA | | YES NO III |
| CERT | E 20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | D. (Enter noture of injury in Port I or Port II of item 18.) |
| A | | ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) |
| MEDIC | Hour o.m. While Not while fo | clory, street, office bldg., etc.) |
| 2 | | Cherry Com Que Constant Comment |
| | 21. I certify that (I) (this haspital) attended the deceased fram | 211 |
| | saw the deceased alive an 1969, and that | Beath accurred at AM, from the causes and an the date stated above. 22b.DATE |
| | A. (11.01 H/10) | M.D. PHYS. MED. STAFF SIGNED |
| | 22c. PHYSICKIN'S | 22d. ADDRESS |
| | NAME (Type) PRANK WOLBERTI | ND HAURE DE GRACE MO. |
| 23 | 3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY, C | OR CREMATORY 23d. LOCATION (City, town, or county) (Stote) |
| | BEMOVAL (Specify) SEPT2/960 ANGEL HI | LL CEM. HAVRE DE GRACE MP |
| 24 | FUNERAL DIRECTOR'S SIGNATURE | 25g. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| V | Madison Mulehell Havred Shace | DATE SEP 6 '60 Circum S. Kinus |

TO HOSPITAL OR ATTENDING PHYSICIAN: Jaw requires that the deoth certificate be executed within 24 has after death. Page 4 may be retained by the hospital or attending Mysician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove corbon pages. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremotion, ar removal, and in any event, within 72 haurs after death.

after death. Poge 4

VR A1S (4) 1SM 9/59



ofter death. Page 4 D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled invery the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remays carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, crematian, or remayal, and in any event within 72 hours ofter death. requires that the deoth certificate be executed within 24 has

moy be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate TO HOSPITAL OR ATTENDING PHYSICIAN:

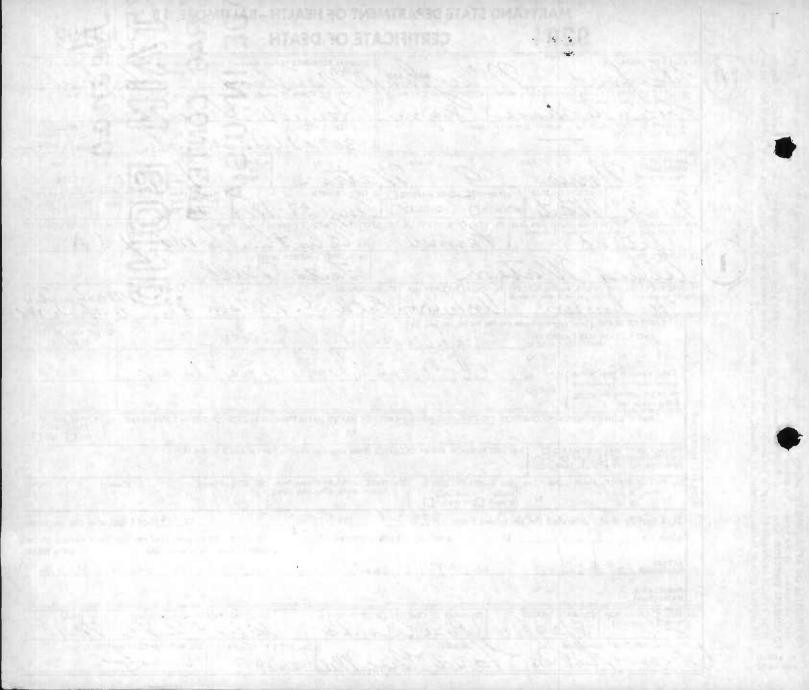
VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9204

CERTIFICATE OF DEATH

09192 Reg. Dist. No.

| | _ | | |
|----|----------------|--|------------------------|
| 1 | 1. PI | PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before own b. COUNTY b. COUNTY | ission) |
| / | b. | b. CITY OR JOWN (If autside corporate limits, write RURAL and give nearest to RURAL and give nea | iwn) |
| | - | Temede Thace funs. Homed Thace at | |
| , | 0 | OK INSTITUTION ON | RESIDENCE I A FARM? |
| | 3. N | NAME OF | □ NO E |
| | (T | (Type or print) Hours a. Watson DEATH 8/26/60 | Yeor 19 |
| | 5. SE | SEX 6. COLOR OF PACE 7. MARRIED AFVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) WIDOWED DIVORCED 7. Manths Doys Hour | 1 |
| | 10a. | a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 DRIHPLACE (State or foreign country) (Returned) (Return | AT COUNTRY? |
| 1 | 13. F. | FATHER'S NAME | • |
| 1 | 4 | alfred Watson Faith Mull | |
| | 15. V (Yes. | . WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address S. T. Wash | mylen |
| | i | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] | DETWEEN! |
| | | PART I. DEATH WAS CAUSED BY: ONSET AN | |
| | | HAMEDIATE CAUSE (a) Phys Canada Vigar Cook | 7 |
| | | Conditions, if any, which) (b) College Charles Security Charles | |
| | | gove rise to immediate couse (o), stating the under- | |
| | _ | lying cause lost. (c) | |
| | CATION | | S AUTOPSY FORMED? |
| | 02 (| 20s. ACCIDENT WAS UNDERLYING A CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| | MEDICAL | 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) | (Stole) |
| | MED | Hour a. m. While Not while at work at work at work | |
| | 2 | 21. I certify that I attended the deceased from \$/22/, 1960, ta \$/26/, 1960, that I last saw the | e deceased |
| 10 | | alive an 1960, and that death accurred at 3 30 12 of from the causes and an the date sta | ited abave. |
| | | ACTUAL MAN 10 6 March 100 100 100 100 100 100 100 100 100 10 | DATE SIGNED |
| | 5 | SIGNATURE (JUNA h. COCOMOLIMO 40) S- CNCO We. There as he | is not stro |
| | 1 | PHYSICIAN'S NAME (Type) | / // |
| | | BURIAL CREMATION, 226. DATE THEREOF 22c NAME OF CEMETERY OF CREMATORY 22d. LOCATION (City, town of county) (SI | ate) |
| | 1 | 8/29/60 Rose Banks Calvert Seel 6. M. | a. |
| 1 | 23. FI | FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 240. REC'D 8Y REGISTRAR 24b. REGISTRAR'S SIGNATURE ADDRESS AD | |
| | | Comment of the partie 30'60 and I thank | |



VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09193

| | 9205 CERTIFICATE OF DEATH | 03133 |
|---|---|--|
| | 1. PLACE OF DEATH o. COUNTY HAR FORD 2. USUAL RESIDENCE (Where decease or STATE MARYLAND) | sed lived. If institution: Residence before admission. COUNTY |
| | HAURE OF GRACE 15 YEARS X Havre | porote limits, write-RURAL and give newest town) |
| | d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION HAPFORD MEMORIAL HISP. d. STREET ADDRESS D. C. | S. IS RESIDENCE ON A FARM? YES NO |
| | 3. NAME OF DECEASED (Type or print) GUY First Middle Lost OF DEAT | H August 15 1960 |
| | 5. SEX 6. COLOR OR RACE 7. MARRIED DIVORCED B. DATE OF, BIRTH WIDOWED DIVORCED DIVORCED 5/23/E3/190 | 9. AGE in years of the state of |
| 1 | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY V. BIRTHPLACE (Sible or foreign during most of working life, even if retired) ORCHARD ORCHARD 14. MOTHER'S MAIDEN NAME | 12. CITIZEN OF WHAT COUNTRY? |
| | JAMES WEST SOFRONA | WEST |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes. no. of Makhnown) (If yes. give ying or dotes of service) UNK DAREL WEST | - HAURE de GRACE RT |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o) DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| | Conditions, if ony, which gove rise to immediate couse (a), stating the under. lying couse last. (b) Hyperturnel Vuentur (b) DUE TO (c) | hienii ? |
|) | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEAR 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH UT 10 FEITHER, NOTIFY MEDICAL EXAMINER) | ASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| | | Port II of item 18.) |
| | Hour a. m. While Not while of work of work to twork to two two two two two two two two two | County) (State) |
| | 21. I certify that (I) (this haspital) attended the deceased fram. 8/15, 190, .ta saw the deceased alive an | m the causes and an the date stated abave. |
| | 220. SIGNATURE M.D. ATTENDING MED. DIRECTOR [| STAFF PHYS. 22b. DATE SIGNED 76-66 |
| | 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS | |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOC BEMOVAL (Specify) 8/18/1960 WEST AND PLUMMER AS | BE COUNTY N.C. |
| | 2. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STREET BY REGION DATE IS 19 16 | 04 |

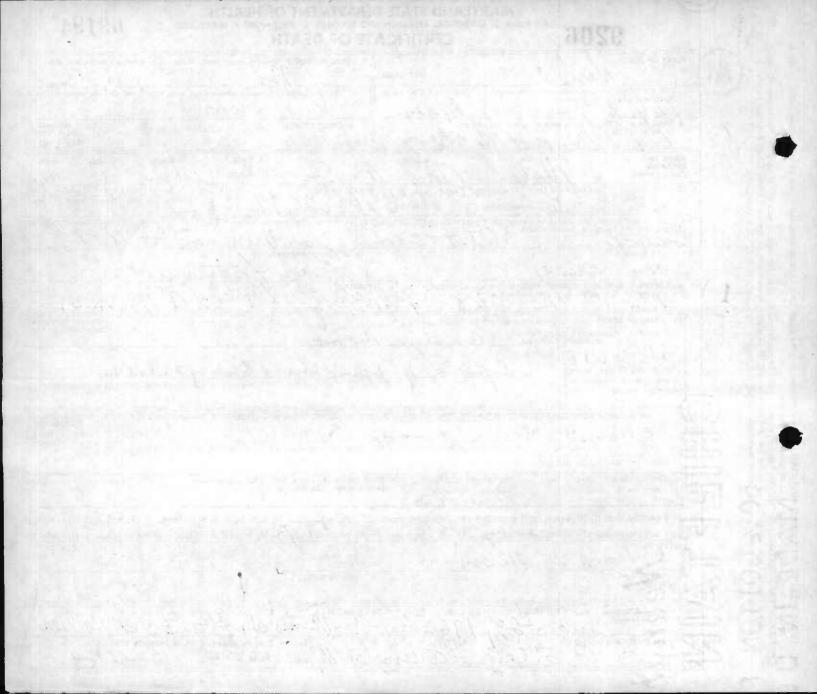
SOUTH CERTIFICA & OT DEATH

| _ | I.hom | | | | |
|---------|--|---|---|---|---|
| | PLACE OF DEATH | 7 7 7 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 2. USUAL RESIDENCE (Where deceas | ed lived. If institution: Residence b | eforg admission) |
| | Harfaid | MARYLAND | 11/11/ | Har | ford |
| | b. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest/town) | c. LENGTH OF STAY IN 16 | VIII L | porate limits, write RURAL and give | nearest town) |
| | d. NAME OF HOSPITAL (If not in haspital, give street a OR INSTITUTION | apital | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES NO |
| 3 | NAME OF | Middle | Jost 4. DATE | Month | Day Year |
| | OECEASED (Type or print) | alice o | Ulchon DEATH | · Cinquest & | 20 1960 |
| S. : | Lemale white widower | D DIVORCED | B. DATE OF BIRTH 1904 | 9. AGE (In years last birther) Months Day | ys Haurs Min. |
| 5 | VISUAL OCCUPATION (Give kind of work dane 10b. K Uning most of working life, even if retired) | (IND/OF BUSINESS OR INDU | STRY 11. BIRTHPLACE (State or fareign | country) 12. CITIZEN | OF WHAT COUNTRY? |
| 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| 0 | Joan Drewer | | Laure te | terman , | |
| (Ye | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. S | 00 8 - 24 4 | NFORMANT WILL | la a Wis | hon |
| | 1B. CAUSE OF DEATH [Enter anly ane couse per line | e for (o), (b), and (c).] | | Į, | NTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | Generalenia | Pent onti | | ONSET AND DEATH |
| | 543 DUE TO | | | | |
| | Conditions, if ony, which) (b) Port | notion of & | except Wher + Lot | otion of Durdend ally | |
| | gove rise to immediate couse (a), stating the under- | | | | 1-4-1 |
| | lying cause lost. (c) | • | | | |
| ON | PART II. OTHER SIGNIFICANT CONDITIONS CO | ONTRIBUTING TO DEATH BU | NOT RELATED TO THE TERMINAL DISEA | SE CONDITION GIVEN IN PART 1(| 19. WAS AUTOPSY PERFORMED? |
| SAT | Esophaged Wicz | E Remontos | e. | | YES NO |
| CERTIF | 200. ACCIDENT WAS UNDERLYING 20b. DESC OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RIBE HOW INJURY OCCURR | D. (Enter noture of injury in Part I or Pa | ort II of item 18.) | |
| MEDICAL | 20c. TIME OF INJURY Manth, Day, Year Hour a.m. p. m. 19 While at work | Nat while fo | ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.) | ty or town) (Cour | nty) (State) |
| | 21. I certify that (I) (this haspital) attended | ed the deceased from | 1 Aug 19.60 ta | 20 Aug 1960 | that (I) (we) last |
| | saw the deceased alive an 20 Aug | (0 | 9 1735 | the causes and an the de | |
| | 220. SIGNATURE French D. Hawk | la- | M.D. PHYS. DIRECTOR [| STAFF | 22b. DATE SIGNED |
| | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | |
| 230 | BURIAL, CREMATION, 23b. DATE THEREOF | 23c. NAME OF CEMETERY (| OR CREMATORY 1/2 23d. LOC | ATION/(City, town, or county) | (State) |
| | REMOVAL (Specify) Orngust 23, | 1960 By | -ail/kimara | Harway | Como |
| 24. | FUNERAL DIRECTOR'S SIGNATURE | ADDRESS Line | 250. REC'D BY REGIS | - 100 | Haus |

TO HOSPITAL OR ATTENDING PHYSICIAN: Naw requires that the death certificate be executed within 24 have after death. Page 4 may be retained by the haspital or attending systetion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the state Board of Health priar to burial, crematian, or remavol, and in any event, within 72 hours after death. after death. Page 4

VR A15 (4) 15M 9/S9



TO DEPUTY MEDICAL EXAMINER: If prifficate should be executed within 24 hours after death. If any by is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the furnal director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA 3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trensit permit File pages 1 and 2 with the State Board of Health, or its designated egent, prior to burial, cremation, or removal, and in any event within 72 hours efter death. VS. A15ME

5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Divisio

| n | 01 3 | 1 A 113 | IICAL KESEAK | CH AND RECORDS, | 301 W. PRESION 3 | INCEL! | BALIMORE | I, MARTLA |
|---|------|---------|--------------|-------------------|------------------|--------|----------|-----------|
| 1 | 22 | 2 | MEDICAL | EXAMINER'S | CERTIFICATE | OF D | PEATH | 09195 |

| 1. PLACE OF DEATH | | | | ICE (Where decess | | Residence before admission) |
|---|-----------------------|------------------------------|--|-------------------------|--------------------------------|---|
| Harfor | •• | MARYLAND | a. STATE Ma | ryland | b. COUNTY H | arford |
| b. CITY OR TOWN (if outside corpo write RURAL and give nearest to | orate limits, own) | c. LENGTH OF STAY IN 16 | 1 2/ | | limits, write RURAL an | nd give nearest town) |
| Edgewo | od | 2 yrs., | | lgewood | | |
| U.S. Army Dis | | spital, give street address) | d. STREET ADDRESS | | | a. IS RESIDENCE ON A FARM? |
| Army Chemical | Center | | Ar | my Chemic | cal Center | YES NO K |
| 3. NAME OF | First | Middle | WOT PANA | 4. DATE | Month | Day Year |
| Type or print) | ARTHUR | A. | WOTTOWA | OF DEATH | Assemble | 1 19 60 |
| 5. SEX 16. COLOR O | R RACE 7 MADDI | ED NEVER MARRIED | B. DATE OF BIRTH | 19. AC | August GE (In years IF UNDER | |
| Male Whi | | | May, 4, 1902 | | Months yrs. | Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind done during most of working life, even | of work 10b. I | CIND OF BUSINESS OR INDUST | | or foreign country | 1 12. CIT | TIZEN OF WHAT COUNTRY |
| Warehouseman | | ost Exchange | Bellevil | le, Illin | nis | U.S.A., |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN | | .010 | |
| John Wottawa | | | Elizabeth | Raceler | | |
| 15. WAS DECEASED EVER IN U.S. ARA | | SOCIAL SECURITY NO. 17. | INFORMANT | DUDDICI | Address | |
| (Yes, no, or unkown) (If yesgiva waror | | 328-03-4528 Ge | ***** | 70 77 | | |
| no 18. CAUSE OF DEATH [Enter of | | | orge Wottawa | Belle | ville III | I INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSE | D RV. | | | | | ONSET AND DEATH |
| IMMEDIATE CA | | conary Artery | | | | |
| du 1 | DUE TO | lrteriosclerot: | ic Cardiovaso | ular Dise | ease. | |
| Conditions, if any, which | (b) | | | | | |
| (a), stating the underlying | DUE TO | | | | | |
| cause last. | (c) | | | | | |
| PART II. OTHER SIGNIFICANT | CONDITIONS CO | NTRIBUTING TO DEATH BUT N | OT RELATED TO THE TERMI | INAL DISEASE CON | DITION GIVEN IN PAR | 1 1(a) 19. WAS AUTOPSY PERFORMED? YES DO NO |
| PART II. OTHER SIGNIFICANT 208. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | | RIBE HOW INJURY OCCURED. | (Enter nature of injury in Pa | et I or Part II of item | 18.) | |
| 20c. TIME OF INJURY Month, Hour a.m. | Whil | eNot While fac | ACE OF INJURY (Home, fer- story, street, office bldg., etc. | | own) (Cou | unty) (State) |
| Print | 19 at wo | | | | | |
| 21. I certify that I took ch | | / /_ | eld an Autopsy X, | Inspection | , Inquiry, | and in my opinion |
| death resulted from: Nat | ura causes X | , Accident , Sui | cide, Homicide | Undete | ermined manner | |
| | 0 | | CHIEF MEDICAL | EXAMINER | | |
| ACTUAL SIGNATURE | mes! | Petter 1 | M.D. ASSISTANT MED | DICAL EXAMINER | 2 | DATE SIGNED |
| EXAMINER'S | | * | DEPUTY MEDICA | L EXAMINER | | 8/2/60 |
| NAME (Type) | harles S | Petty. M.D. | Address (Streat, | elty, town, or coun | ty) | 0/4/00 |
| 22a. BURIAL, CREMATION, 22b. DAT | TE THEREOF | 22c. NAME OF CEMETERY C | R CREMATORY | 22d. LOCATION | (City, town, or country | (State) |
| REMOMA (Specify) Aug. | 3,1960 | Renner & Sons | F.H., | Bellevil | le | Ill., |
| 23 FUNERAL DIRECTOR | | ADDRESS | 24a. RE | | 24b. REGISTRAR'S S | IGNATURE |
| Howard Killie | my 1 | Abingdon, N | Maryland .DATE | UG 5 '60 | Orthur & | Krues |
| 1 10 .00 .01 | 0 | | | | | |

